AUDITOR GENERAL
Alberta

Report of the Auditor General on Seniors Care and Programs

May 2005

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Ms. Janis Tarchuk, MLA
Chair
Standing Committee on Legislative Offices

I am honoured to send you my report titled "Report of the Auditor General on Seniors Care and Programs" dated May 2005.

Fred J. Dunn, FCA
Auditor General

Edmonton, Alberta
May 2, 2005

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Introduction

This is a report about how the government can improve its systems to deliver care and programs to Alberta's seniors.

Systems for delivery of care and programs require significant improvement

We examined the systems used to deliver services in long-term care facilities, the Seniors Lodge Program and the Alberta Seniors Benefit Program. We concluded that the systems require significant improvement. Our key findings are that:

- standards for the provision of nursing and personal care and housing services in long-term care facilities and standards for the Seniors Lodge Program are not current,
- standards are needed for services delivered in assisted living and other supportive living facilities,
- systems to monitor compliance with standards for both long-term care facilities and lodges are not adequate, and
- the Departments require further information to assess the effectiveness of the services and programs.

Long-term care facilities not complying with all care and housing standards

We also visited a sufficient number of long-term care facilities to assess, against provincial standards, the quality of care and services provided across the province. The following table shows the percentage of standards met by the facilities.

Standards	Met
Basic Standards – care	68.7%
Basic Standards – housing	88.6%
Basic Standards – administration	49.3%

We are most concerned that the facilities did not meet the care standards for:

- providing medication to residents,
- maintaining medical records, particularly the application and recording of physical and chemical restraints, and
- developing, implementing and monitoring resident care plans.

Services and programs for seniors

The Alberta government offers many services and programs for seniors. These services and programs are delivered by the Departments of Health and Wellness and Seniors and Community Supports, regional health authorities (Authorities), and various other boards and agencies including private and not-for-profit contracted service providers. Many different health care

professionals, their related associations and other professional organizations are also involved.

Health, social, housing and personal care services are provided by the Government of Alberta to seniors in a variety of settings. The names for describing these settings vary throughout the province. In this report, settings are defined as follows:

- facility based settings—long-term care facilities including both nursing homes and auxiliary hospitals. Residents in these facilities receive 24-hour nursing care, personal care and housing services. There are 179 long-term care facilities in the province with approximately 14,000 beds—see page 19.
- supportive living settings—there are many types of supportive living settings including assisted living, designated assisted living, lodges, enhanced lodges, seniors complexes and group homes. Residents in these settings do not require 24-hour nursing and personal care services but may receive a variety of nursing care, personal care and housing services. The nature and extent of the care and services varies between settings. There are 143 lodges with 8,500 beds and approximately 12,000 beds in other supportive living settings—see page 43.
- home living settings—these include single dwellings and apartments. Residents of these settings typically receive home care health services.

We decided to examine a number of these services and programs because:

- seniors represent a vulnerable segment of our population since many of them need to rely on others for their financial and physical support,
- Alberta's population is aging and the cost of seniors care and programs is likely to increase,
- members of the public, professional organizations and members of the Legislative Assembly encouraged us to examine and report on the extent to which the programs and services were meeting seniors needs,
- Albertans, through their taxes, pay a significant amount for these programs and services, and
- service delivery systems are complex.

Our audit

Examined services in long-term care facilities, Seniors Lodge Program and Alberta Seniors Benefit Program

We examined services provided to seniors in long-term care facilities, the Seniors Lodge Program and the Alberta Seniors Benefit Program. Services in long-term care facilities and the Seniors Lodge Program were selected because residents in these facilities now tend to be older with more nursing and personal care needs than in past years. This trend is a result of the government's direction to have individuals stay in their homes or supportive

living settings as long as possible and to have long-term care facilities focus on those individuals with more complex needs. We selected the Alberta Seniors Benefit Program because it is the primary provincial program providing financial support to seniors in Alberta, many of whom live in long-term care facilities and lodges.

The annual cost of these services and programs is as follows:

- Long-term care services estimated at $750 million
- Seniors Lodge Program $15 million
- Alberta Seniors Benefit Program $178 million

Examined Department systems to manage seniors services and programs

Our overall objective was to determine if the Departments of Health and Wellness and Seniors and Community Supports had appropriate systems in place to manage seniors care and programs. Our audit was extensive and included examining the systems used by the Departments, Authorities, management bodies (also referred to as lodge operators), and long-term care facility operators to manage these services and programs.

Examination included 9 Authorities, 25 long-term care facilities and 20 lodge operators

We examined the systems of the 9 Authorities in the Province, 25 long-term care facilities and 20 lodge operators. Authorities are responsible for the delivery of long-term care services in their region, therefore, we visited all Authorities and at least one long-term care facility in each Authority. The objective of our visits to long-term care facilities was to obtain evidence about the quality of care and services being provided in such facilities across the province. Our audit teams that visited the long-term care facilities included health care professionals and advisors. Our sample of long-term care facilities and lodge operators is representative of these organizations across the province. The purpose of visiting these organizations was to obtain direct evidence of the effectiveness of the systems as a whole across the province and was not to rank the Authorities, facilities and lodges. An overview of the audit scope and approach is included in Appendix D—see page 89.

Recommendations

7 recommendations to improve services in long-term care facilities

This report includes seven recommendations to the Department of Health and Wellness designed to improve the systems used to provide services in long-term care facilities. The key recommendations are for the Department to update the Basic Service Standards, ensure that they are current and monitor compliance with them. Another key recommendation is the need for the Department to measure the effectiveness of long-term care services. These recommendations and supporting comments are included in the chapter of this report titled *Services in long-term care facilities*—see page 15.

3 recommendations on Seniors Lodge Program and 1 recommendation on supportive living facilities

Our report also includes three recommendations to the Department of Seniors and Community Supports on the Seniors Lodge Program. As with long-term care, we make key recommendations to update, maintain and ensure compliance with Lodge Standards. Other recommendations show that the Department needs to improve the measurement of the effectiveness of the program and periodically assess if the minimum disposable income of seniors, used as a basis to determine lodge rent charges, is appropriate. These recommendations and supporting comments are included in the chapter of this report titled *Services in supportive living settings*—see page 43. This section also contains a key recommendation to the Departments of Health and Wellness and Seniors and Community Supports to establish standards for services provided in assisted living and other supportive living settings.

2 recommendations on the Alberta Seniors Benefit Program

The chapter of this report titled *Alberta Seniors Benefit Program* contains two recommendations to the Department of Seniors and Community Supports. We recommend that the Department obtain further information to set the program's income threshold, cash benefits and supplementary accommodation benefits—see page 53.

Summary of recommendations and management responses

A summary of all recommendations together with responses from senior management of the Departments of Health and Wellness and Seniors and Community Supports is in the next section—see page 7.

Also included in this report are our findings from visits to Authorities (Appendix A—see page 59), long-term care facilities (Appendix B—see page 69), and lodge operators (Appendix C—see page 83). Our report does not identify individual facilities or lodge operators because our sample was selected to be representative of facilities and lodges across the province. Our intention was to identify systemic concerns and make recommendations applicable to the province as a whole. For the same reason, we have not identified the Authorities to which facilities belong because our sample is representative of all, not specific, Authorities.

We have reported our findings to the Departments, Authorities, facilities and lodge operators for resolution and follow-up.

The future

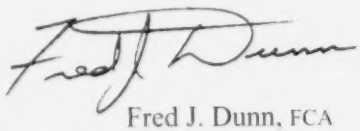
Recommendations will help improve quality of care and programs

We believe implementing these recommendations will:

- improve the quality of care and programs for seniors,
- enable the Departments to make informed decisions about the effectiveness of the programs,

- improve accountabilities in a complex structure that relies on contracted service providers, and
- improve Albertans' understanding of and confidence in the systems to deliver care and programs for seniors.

We acknowledge the cooperation, assistance and encouragement we received during this audit from staff in the Departments of Health and Wellness and Seniors and Community Supports, the Authorities, long-term care facilities and lodge operators.



Fred J. Dunn, FCA
Auditor General

April 13, 2005

Summary of recommendations and management responses

Indicates a key recommendation

Green print – other numbered recommendations

Black print – unnumbered recommendations

Services in long-term care facilities

See page 29

Developing and maintaining standards—Recommendation No. 1

We recommend that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Management response

Alberta Health and Wellness: Agreed. The department will work with Regional Health Authorities, and the Department of Seniors and Community Supports to update all provincial and regional Continuing Care Health Service Standards. The new Continuing Care Health Service Standards will include a system of regular review involving Regional Health Authorities and stakeholders so that the standards are able to be updated quickly to reflect best practices. The new Continuing Care Health Service Standards will be prepared in 2005, with opportunity for public and stakeholder review, and fully implemented in 2006.

Alberta Seniors and Community Supports: Agreed. The Department of Seniors and Community Supports, in collaboration with the Department of Health and Wellness and the Regional Health Authorities, is currently updating the accommodation standards for long-term care facilities. A system will be implemented to regularly review and update these standards.

See page 31

Compliance with Basic Service Standards—Recommendation No. 2

We recommend that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Management response

Alberta Health and Wellness: Agreed. The department will work with Regional Health Authorities and the Department of Seniors and Community Supports to improve the systems for monitoring the compliance of long-term care facilities with the Continuing Care Health Service Standards.

Alberta Seniors and Community Supports: Agreed. The Department of Seniors and Community Supports is working with the Department of Health and Wellness and the Regional Health Authorities to establish effective monitoring systems for compliance with basic accommodation standards.

See Page 34

Effectiveness of services in long-term care facilities—Recommendation No. 3

We recommend that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, assess the effectiveness of services in long-term care facilities.

Management response

Alberta Health and Wellness: Agreed. The department, Regional Health Authorities and long-term care facility operators will continue to implement the Continuing Care System Project that is introducing new care assessment, planning and monitoring tools, which contain quality indicators for measuring effectiveness of service in long-term care facilities. The department will also consult with Alberta Seniors and Community Supports and Regional Health Authorities to develop measures for cost effectiveness of long-term care services.

Alberta Seniors and Community Supports: Agreed. In the 2005-08 Business Plan, the Department of Seniors and Community Supports has developed a new performance measure - "*Quality of accommodation services provided in long-term care facilities, as indicated by satisfaction of residents/families/guardians*" to assess the effectiveness of accommodation services. The Department will continue to work with the Department of Health and Wellness and Regional Health Authorities to develop systems to assess the effectiveness of services in long-term care facilities.

See page 35

Effectiveness of services in long-term care facilities—Recommendation No. 4

We recommend that the Department of Health and Wellness, working with the Department of Seniors and Community Supports, collect sufficient information about facility costs from the Regional Health Authorities and long-term care facilities to make accommodation rate and funding decisions.

Management response

Alberta Health and Wellness: Agreed. The department will work with the Department of Seniors and Community Supports, and Regional Health Authorities, to collect additional information to support accommodation rate decisions by the Department of Seniors and Community Supports, and to support health care service funding decisions by Alberta Health & Wellness and Regional Health Authorities.

Alberta Seniors and Community Supports: Agreed. The Department of Seniors and Community Supports now has the responsibility for setting accommodation rates in long-term care facilities. Reporting requirements have been established to receive information on accommodation-related expenditures from facility operators.

See page 37

Information to monitor compliance with legislation

We recommend that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, identify the information required from long-term care facilities to enable the Departments and Authorities to monitor their compliance with legislation.

Management response

Alberta Health and Wellness: Agreed. The department will work with the Department of Seniors and Community Supports, and the Regional Health Authorities, to include provisions for monitoring and reporting on compliance with legislation and standards in the new Continuing Care Health Service Standards.

Alberta Seniors and Community Supports: Agreed. This will be accomplished in conjunction with the establishment of the system to monitor compliance with accommodation standards.

See page 39

Determining future needs for services in long-term care facilities—Recommendation No. 5

We recommend that the Department of Health and Wellness, working with Regional Health Authorities and the Department of Seniors and Community Supports, develop a long-term plan to meet future needs for services in long-term care facilities. We also recommend that the Departments publicly report on progress made towards goals in the plan.

Management response

Alberta Health and Wellness: Agreed. The department will work with Regional Health Authorities, and Alberta Seniors and Community Supports, to develop long-range plans to meet future needs for services in long-term care facilities. The departments will report publicly on progress towards the goals in the plans.

Alberta Seniors and Community Supports: Agreed. In recognition of the changes being experienced in continuing care, the Department of Seniors and Community Supports will work with the Department of Health and Wellness and Regional Health Authorities to develop a long term plan to address the future needs of services in long-term care facilities. Progress made towards goals in the plan will be reported to the public via regular reporting process.

See page 39

Determining future needs for services in long-term care facilities

We recommend that the Department of Health and Wellness require Regional Health Authorities to periodically update and report on progress implementing their Ten–Year Continuing Care Strategic Service Plans.

Management response

Alberta Health and Wellness: Agreed. The department will require Regional Health Authorities to include longer term planning for continuing care services as part of the 3-year health planning process already underway.

Services in supportive living settings

See page 45

Standards for services in assisted living and other supportive living settings—Recommendation No. 6

We recommend that the Department of Health and Wellness and the Department of Seniors and Community Supports establish standards for care and housing services provided in assisted living and other supportive living settings.

Management Response

Alberta Health and Wellness: Agreed. The department will work with the Department of Seniors and Community Supports to consider applying the new Continuing Care Health Service Standards in other housing, assisted living and supportive living service streams, and to co-ordinate health care standards with accommodation service standards.

Alberta Seniors and Community Supports: Agreed. The Department of Seniors and Community Supports has initiated processes, in collaboration with the Department of Health and Wellness, Regional Health Authorities and housing providers, to develop essential/basic accommodation standards for assisted living and other supportive living facilities.

See page 48

Developing and monitoring standards for the Seniors Lodge Program—Recommendation No. 7

We recommend that the Department of Seniors and Community Supports:

1. **update the Seniors Lodge Standards and implement a process to maintain them.**
2. **improve its systems to monitor management bodies' compliance with the Seniors Lodge Standards.**

Management Response

Alberta Seniors and Community Supports: Agreed. The Department of Seniors and Community Supports has provided funding and support to update the current lodge standards. Once updated, the Department will ensure that the standards are maintained. The Department will also monitor compliance when the revised standards are implemented.

See page 49

Effectiveness of Seniors Lodge Program—Recommendation No. 8

We recommend that the Department of Seniors and Community Supports:

1. **improve the measures it uses to assess the effectiveness of the Seniors Lodge Program.**
2. **obtain sufficient information periodically to set the minimum disposable income of seniors used as a basis for seniors lodge rent charges.**

Management Response

Alberta Seniors and Community Supports: Agreed in principle.

1. The key objective of the program is to provide supportive housing for lower income seniors and through information the department currently receives, 89% of lodge residents have low to moderate income. As well, the quality of services will be further monitored through proposed systems included in our response to Recommendation #7.
2. The Department of Seniors and Community Supports will continue to monitor the senior lodge rent rates in relation to the minimum disposable income of seniors annually.

See page 50

Determining future needs

We recommend that the Department of Seniors and Community Supports improve its processes for identifying the increasing care needs of lodge residents and consider this information in its plans for the Seniors Lodge Program.

Management Response

Alberta Seniors and Community Supports: Agreed. The Department of Seniors and Community Supports will work with the Department of Health and Wellness and Regional Health Authorities to improve processes for identifying the increasing care needs of lodge residents and will consider this information in its plans for the Seniors Lodge Program.

Alberta Seniors Benefit Program

See page 55

Effectiveness of the Alberta Seniors Benefit Program

We recommend that the Department of Seniors and Community Supports improve the measures it uses to assess whether it is meeting the objective of the Alberta Seniors Benefit Program.

Management Response

Alberta Seniors and Community Supports: Agreed. The Department of Seniors and Community Supports uses income as a tool to assess the need for financial assistance. The Department will look to improve and develop senior specific model(s) and datasets to better identify seniors' financial needs.

See page 56

Information to determine program benefits—Recommendation No. 9

We recommend that the Department of Seniors and Community Supports obtain further information necessary to make income threshold, cash benefit and supplementary accommodation benefit decisions for the Alberta Seniors Benefit Program.

Management Response

Alberta Seniors and Community Supports: Agreed. As stated in the Management Responses above, the Department of Seniors and Community Supports will be looking to improve and develop senior specific model(s) to aid in the decision making process.

Services in long-term care facilities

Conclusions

Basic Standards not current

The Department of Health and Wellness has set Basic Service Standards (Basic Standards) for services provided in long-term care facilities; however, the Basic Standards are not current and the Department does not have systems in place to develop, maintain and update the Basic Standards. Regional health authorities (Authorities) have implemented guidelines or policies to supplement the Basic Standards in their regions—see page 29.

System to monitor compliance with Basic Standards needs to be improved

The Department does not have an adequate system to monitor long-term care facilities' compliance with Basic Standards. The Department relies on the Authorities, the Health Facilities Review Committee (HFRC) and the Protection for Persons in Care Office (PPIC) to monitor whether the facilities comply with Basic Standards. However, only one Authority recently started inspecting its facilities for compliance with all the Basic Standards. Further, HFRC and PPIC do not inspect facilities for compliance with the Basic Standards and do not have enforcement mechanisms to ensure that facilities rectify non-compliance. During our facility visits, we found that 31% of the Basic Standards relating to care were not met—see page 31.

Department does not have information to assess quality and cost-effectiveness

The Department currently lacks information to assess the quality and cost-effectiveness of services in long-term care facilities. The Department obtains some information from Authorities about wait lists and certain financial information. However, this information is not sufficient to allow the Department to assess the effectiveness of services provided in long-term care facilities. Nor is this information sufficient for making funding decisions, setting accommodation rates, or assessing policy changes. The Department has taken steps to correct some of these deficiencies but will not have information to measure quality of resident care in all regions of the province until the 2007–08 fiscal year—see page 34.

Department does not have sufficient information to monitor compliance with legislation

The Department has not identified the information that it requires from the facilities to enable it to monitor their compliance with legislation. The agreements between Authorities and facilities vary significantly among the Authorities and often do not require sufficient management information from the facility operators—see page 37.

No long-term plan to meet future needs for services in long-term care facilities

The Department and Authorities have projected future needs for services and capital requirements for long-term care facilities. However, the Department does not have a long-term plan to meet future needs for services in long-term care facilities and supportive living settings. Also, the Department does not receive sufficient information from the Authorities to fully understand the Authorities' progress in meeting long-term needs—see page 39.

Background

This background has ten sections:

1. **Introduction**—types of continuing care services offered in Alberta.
2. **Roles and responsibilities**—roles and responsibilities of the Ministers, Departments, and Authorities.
3. **Long-term care facilities**—information on the number and type of long-term care facilities in Alberta.
4. **Services and costs**—types of services provided in long-term care facilities, as well as the rates charged to residents.
5. **The residents**—how Authorities measure the needs of long-term care residents.
6. **The caregivers**—types of groups that provide care to residents in long-term care facilities.
7. **Developing and maintaining Basic Service Standards**—what the Basic Standards cover.
8. **Monitoring compliance with Basic Service Standards in facilities**—Canadian Council on Health Services Accreditation, Health Facilities Review Committee, and Protection for Persons in Care Office.
9. **Funding for regional health authorities and facilities**—types of funding provided by the Department to Authorities, and how Authorities fund long-term care facilities.
10. **Determining future needs for continuing care services**—the Department's processes for determining future needs.

1. Introduction

Continuing care services are a broad range of health, social and personal care services provided by the Government of Alberta to both seniors and non-seniors in the following settings:

Table 1 – Continuing Care Services[1]

Possible Settings				
Single Dwellings/ Apartments	Other Supportive Living facilities – for example, Seniors Complexes and Group Homes	Lodges/ Enhanced Lodges	Assisted Living/ Designated Assisted Living	Long-Term Care Facilities – Nursing Homes and Auxiliary Hospitals
Home Living Settings	Supportive Living Settings			Facility Based Settings

Long-term care facilities include both nursing homes and auxiliary hospitals, and provide residents with 24-hour nursing care, personal care and housing services. Nursing homes are governed by the *Nursing Homes Act* and *Regulations*. The standards of care and services to be provided in a nursing home are detailed in the *Nursing Homes Operations Regulation*. Auxiliary hospitals are governed by the *Hospitals Act* and *Regulations*.

2. Roles and responsibilities

Minister of Health and Wellness

The Minister of Health and Wellness:

- sets the overall direction, priorities and expectations, including standards,
- allocates resources,
- ensures the delivery of quality health services, which includes access to services and ensuring there are appropriate processes in place to resolve the health concerns of individuals, and
- measures and reports on the performance of the health system to the legislative assembly and the public.

The Minister has rights under the *Nursing Homes Act* to:

- make regulations on what basic services must be offered, the level of staffing and operation of nursing homes, and
- enter and inspect facilities and cancel contracts or appoint an administrator for the facility if residents are at risk or legislation has been contravened.

[1] Department of Health and Wellness, Health Aging: New Directions for Care, Part Three: Implementing New Directions, November 1999, p.45

Department of Health and Wellness:

The role of the Department of Health and Wellness is to assist the Minister to fulfill his or her duties. The Department's responsibilities include:

- monitoring and ensuring regional health authorities' compliance with legislation and Basic Standards,
- making recommendations about regional health authority business plans and budgets, and providing funds, and
- evaluating the performance of the health system.

Transfer of responsibility for housing services

Responsibility for housing services in long-term care facilities transferred

In June 2003, the Cabinet decided that the Minister of Seniors and Community Supports should be responsible for the housing services delivered in long-term care facilities. Previously, housing services were included with other services provided in long-term care facilities under the responsibility of the Department of Health and Wellness. Continuing care services provided in long-term care facilities are to remain the responsibility of the Department of Health and Wellness.

Effective April 1, 2005, the Minister of Seniors and Community Supports is responsible for making regulations for determining accommodation rates and managing resident trust accounts in long-term care facilities. The Department of Seniors and Community Supports will work with the Department of Health and Wellness and Authorities to identify and obtain the information it needs to fulfill the Minister's responsibilities, update the Basic Standards for housing services, and monitor these Basic Standards.

Regional health authorities

The nine Authorities are accountable to the Minister of Health and Wellness for meeting the responsibilities conferred on them by the Legislative Assembly, primarily under Section 5 of the *Regional Health Authorities Act*. Authorities are responsible for:

- planning and delivering appropriate long-term care services and ensuring that residential care is available for people whose long-term care needs can no longer be met in the community,
- adhering to provincial standards in delivering services, and
- complying with other federal, provincial and municipal legislation including the *Health Professions Act*.

Authorities' responsibilities for the delivery of services in long-term care facilities are broadly outlined in the *Nursing Homes Act*, the *Public Health Act*, and the *Hospitals Act*.

The Minister has established an accountability framework that requires Authorities to submit to the Minister:

- A Three-Year Health Plan and a draft Annual Business Plan by December 31 each year.
- A final Annual Business Plan by March 31, once the provincial government budget has been approved.
- Quarterly reports of performance and financial results.
- An Annual Report within four months after the end of the fiscal year.

3. Long-term care facilities

Long-term care facilities are owned and operated either by:

- Authorities (public facilities),
- corporations or individuals under contract to Authorities (private facilities), or
- voluntary, cultural or religious organizations under contract to Authorities (voluntary facilities).

Table 2 shows the ownership, number of facilities and number of beds in each region at December 31, 2004:

Table 2 -- Facilities and Beds[2]

Authority	Public		Private		Voluntary		Total	
	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds
1. Chinook Regional Health Authority	7	277	3	289	2	240	12	806
2. Palliser Health Region	4	133	5	339	1	80	10	552
3. Calgary Health Region	15	1,239	17	2,219	10	1,046	42	4,504
4. David Thompson Regional Health Authority	18	1,055	1	73	6	277	25	1,405
5. East Central Health	12	571	1	60	4	311	17	942
6. Capital Health	8	1,157	12	1,188	14	2,107	34	4,452
7. Aspen Regional Health Authority	17	578	5	251	1	30	23	859
8. Peace Country Health	11	421	1	60	0	0	12	481
9. Northern Lights Health Region	4	64	0	0	0	0	4	64
Totals	96	5,495	45	4,479	38	4,091	179	14,065

[2] Data supplied by regional health authorities, February 2005

The relative proportions of public, private and voluntary facilities vary from region to region. Overall, 39% of long-term care beds are in public facilities, 32% are in private facilities and 29% are in voluntary facilities.

The trend in waiting lists for long-term care facilities in Alberta is as follows:

Table 3 – Waiting lists for long-term care facilities[3]

Year ended	Waiting in acute care hospital	Waiting urgently in community	Total
March 31, 2001	385	377	762
March 31, 2002	351	378	729
March 31, 2003	340	457	797
March 31, 2004	267	339	606

4. Services and costs

Nursing care services, personal care services, medical or surgical supplies and medications are provided at no cost to residents of long-term care facilities. The cost of these services and supplies are paid by the Authorities. However, residents must pay user fees for personal expenses such as laundry, clothing, and hair care, as well as a monthly charge for their accommodation.

The Department sets the maximum daily accommodation rate that long-term care facilities can charge residents. The following is a summary of the maximum rates from 1994 to present:

Table 4 – Daily accommodation rates[4]

Room type	Starting April 1, 1994	Starting January 1, 2002	Starting August 1, 2003
Standard	$24.75	$28.22	$39.62
Semi-private	$26.25	$29.93	$42.00
Private	$28.60	$32.60	$48.30

5. The residents

Admission of residents into facilities

Individuals most often come to a long-term care facility from either acute care hospitals or from the community on an urgent basis. They are placed in long-term care facilities on the basis of "first available bed". Facilities or their governing organizations typically have the right to refuse a prospective resident if they are unable to meet the resident's individual care requirements.

[3] Alberta Health and Wellness 2001 to 2004 Annual Reports

[4] *Nursing Homes Operation Regulation* 3(1), AR 115/94, AR 221/2001, AR 260/2003

Measuring residents' functional care needs—Case Mix Measure

Residents rated from A to G based on functional care needs

Authority health professionals measure residents' needs on an annual basis, using a scale from A to G, based on four functions of daily living (eating, toileting, transferring, and dressing), two behaviour indicators (potential for injury to self or others and ineffective coping), and two continence indicators (urinary and bowel). A rating of A indicates the lowest level of care needs; a rating of G indicates the highest level of care needs. These indicators measure the amount of personal care the resident would typically receive from personal care attendants to accomplish daily functions. However, the indicators do not measure the complexity or stability of the resident's medical conditions or the extent of intervention required.

Resident functional care need ratings, from A to G, are numerically weighted by Authorities and aggregated to calculate a facility Case Mix Measure (CMM), which is a measure of the overall functional care needs at a facility. Currently, facility CMMs across Alberta range from approximately 74 to 121. A higher CMM indicates a greater proportion of residents with higher overall functional care needs.

Over 75% of residents are in the highest categories of functional care needs

The following table shows overall regional CMMs for Alberta's nine Authorities and also indicates that at the end of 2003, over 75% of long-term care residents were in the highest three categories of functional care need. The total number of residents in this table does not exactly match the number of beds in Table 2 because of timing differences in gathering the information.

Table 5 – CMM ratings by Authority – 2003[5]

	Number of residents in each category								
Authority	A	B	C	D	E	F	G	Total	CMM
1. Chinook Regional Health Authority	1	52	56	106	123	389	59	786	94.64
2. Palliser Health Region	0	14	27	62	112	179	56	450	98.60
3. Calgary Health Region	4	205	315	484	755	1,480	591	3,834	98.98
4. David Thompson Regional Health Authority	4	77	76	154	221	525	216	1,273	100.81
5. East Central Health	1	42	54	130	122	364	189	902	103.80
6. Capital Health	3	194	234	485	771	1,745	746	4,178	102.52
7. Aspen Regional Health Authority	6	47	52	118	144	393	53	813	93.61
8. Peace Country Health	0	16	25	58	70	176	87	432	104.04
9. Northern Lights Health Region	2	6	10	7	6	32	1	64	85.45
Totals/Average	21	653	849	1,604	2,324	5,283	1,998	12,732	100.16
Percentage of total beds	0.2%	5.1%	6.7%	12.6%	18.3%	41.5%	15.7%	100%	

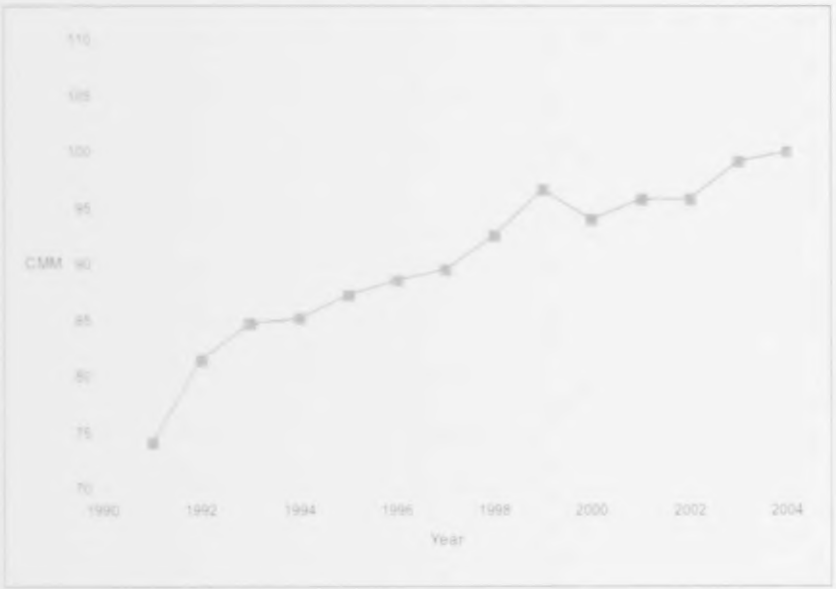
Residents' functional care needs increasing

Higher medical and functional needs now than in the past

Because CMMs have been used to measure the functional needs of residents since prior to 1990, changes in overall functional needs of residents in long-term care facilities can be calculated. The following chart shows that long-term care residents' functional needs are approximately 35% higher today than in 1990, and the overall provincial CMM has steadily increased. The emphasis on remaining close to one's community, or "aging in place" as an overall continuing care strategy results in people remaining at home longer. As a result, individuals entering long-term care facilities have more complex health conditions, behavioural issues, and higher functional needs. This results in challenges in meeting human resources and continuing staff education needs.

[5] Data supplied by Department of Health and Wellness, 2003

Chart 1 – Provincial CMM[6]



6. The caregivers

Four caregiver groups provide nursing and personal care in long-term care facilities:

- Registered Nurses (RNs)—are regulated by the Alberta Association of Registered Nurses. RNs typically have completed a minimum two-year diploma program, and many complete a four-year university degree program.
- Registered Psychiatric Nurses (RPNs)—are regulated by the Registered Psychiatric Nurses Association of Alberta. RPNs typically have completed a minimum two-year diploma program, and many complete a four-year university degree program.
- Licensed Practical Nurses (LPNs)—are regulated by the College of Licensed Practical Nurses of Alberta. LPNs typically have completed a 15-month study program in a college setting.
- Personal Care Attendants (PCAs)—are an unregulated group of workers trained on the job, and students and graduates of PCA certification programs at colleges and vocational schools, which vary from 12 to 40 weeks.

The Health Professions Act requires all health professional colleges to follow common rules to investigate complaints and set educational and practice standards for registered members. The Act is effective for a profession once the

[6] Data supplied by Department of Health and Wellness, 2003

profession's specific schedule to the Acts is proclaimed in force and its regulations are approved by the Lieutenant Governor in Council. The College of Licensed Practical Nurses of Alberta has been regulated by the Act since April 12, 2003. RNs and RPNs are currently in the process of having their regulations reviewed by the Department of Health and Wellness. RNs and RPNs continue to be regulated under the *Nursing Profession Act* and the *Health Disciplines Act*, respectively.

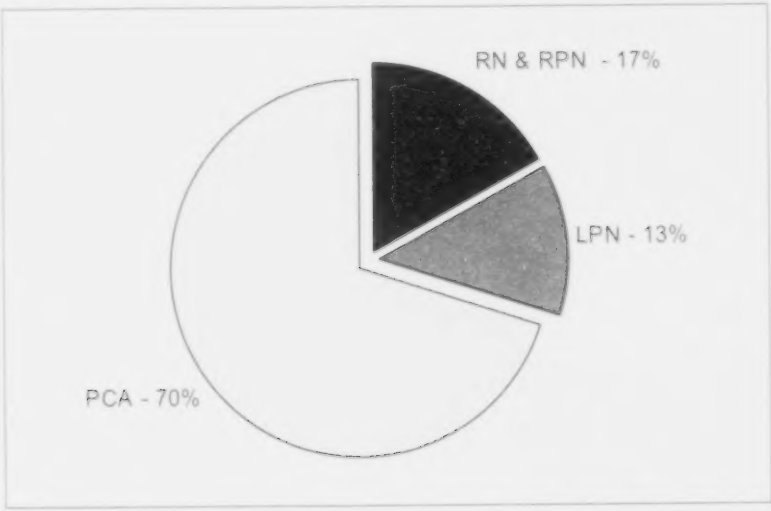
The Department has recently developed a curriculum for PCA training in publicly funded colleges and vocational schools in the Province. This curriculum is designed to attain a consistency in PCA training and contribute to the overall competency of workers in the PCA field. However, completion of this curriculum before working as a PCA will not be mandatory.

At December 31, 2004, the number of full-time equivalent positions (FTEs) employed in long-term care facilities in Alberta were:[7]

- 1,268 RN and RPN
- 944 LPN and
- 5,268 PCA

RNs and RPN numbers are combined due to the relatively low number of RPNs working in long-term care facilities.

Chart 2 – Nursing and personal care FTEs working in long-term care facilities



[7] Data supplied by all regional health authorities, February 2005

70% of care provided by PCAs

PCAs typically provide approximately 70% of resident care hours, with professional nurses (RNs, RPNs and LPNs) providing the balance. Accordingly, there is a critical supervisory and mentorship role for RNs, RPNs and LPNs to ensure PCAs are providing safe, competent care. Such care also requires the PCA to consistently recognize resident symptoms that require professional assessment and intervention.

An aging and difficult-to-recruit workforce

Recruiting for long-term care difficult

Providing long-term care for individuals with chronic medical conditions and severe functional limitations can often be more physically and mentally demanding than some other health care specialties. Accordingly, many health care professionals may choose career paths other than in long-term care facilities and recruitment for long-term care positions is challenging.

Nurses aging

Nursing demographics indicate an aging workforce that will face continual challenges in this physically demanding field as their retirement ages approach. In Alberta, approximately 67% of RNs[8], 55% of RPNs[9] and 47% of LPNs[10] were over the age of 45 in March 2004. Statistics are not available to identify the age groups for PCAs.

In 2003, the Personnel Administration Office reviewed "hard to recruit" positions and locations in the government. This review acknowledged the challenges of recruiting health professionals, and identified the health sector as a sector at risk due to the increased health care needs of an aging population. The review recommended that the government partner with colleges and universities for practicum, work experience, summer placements and internships, as well as offer options for learning, such as distance learning and videoconferencing.[11]

7. Developing and maintaining Basic Service Standards

Minister responsible for setting standards

The Minister of Health and Wellness is responsible for setting standards for long-term care facilities. *Basic Service Standards for Continuing Care Centres*[12] cover care, housing and administration services. Authorities can set higher standards as well as policies and procedures to implement the Basic Standards in their region. A more complete description of the Basic Standards is included in Appendix D. The Basic Standards cover the following areas:

[8] Data supplied by Alberta Association of Registered Nurses
[9] Data supplied by Registered Psychiatric Nurses Association of Alberta
[10] Data supplied by College of Licensed Practical Nurses of Alberta
[11] Hard to Recruit Positions & Locations in the Alberta Public Service, May 2004
[12] Department of Health and Wellness, April 1995

Basic Standards—care

Facilities must provide residents with nursing and personal care services such as assistance with dressing, bathing, and eating. They also must supply residents with medication and special therapeutic diets prescribed by a physician, diagnostic services, and access to other health services such as physicians. Facilities should have good medical record keeping, including personal care plans, and report as required by legislation and policies.

Basic Standards—housing

Facilities must provide adequate and appropriate meals, laundry, and housekeeping. They must also ensure that the residents' surroundings are maintained properly, with adequate safety and security programs for residents and staff. Facilities must bill residents the appropriate accommodation charges.

Basic Standards—administration

Facilities must adequately monitor and report their quality of care and provide trust accounts for residents.

8. Monitoring compliance with the Basic Service Standards in facilities

The Department and Authorities rely, in varying degrees, on the following three organizations to monitor facilities' compliance with the Basic Standards; however, none of these organizations are specifically required to monitor compliance with the Basic Standards:

Canadian Council on Health Services Accreditation

CCHSA accredits Authorities, not facilities

The Canadian Council on Health Services Accreditation (CCHSA) is a national, not-for-profit, independent organization that accredits health service organizations. The CCHSA sets standards for health services delivery and accredits organizations if they operate in accordance with the standards. In Alberta, Authorities are accredited rather than individual facilities. Accreditation includes self-assessment and a peer review by surveyors from outside the organization. The CCHSA surveyors compare an organization's services and methods of operating against the national standards. CCHSA makes recommendations to the organization to assist it in developing plans to improve weak areas and maintain strong areas.

Health Facilities Review Committee

HFRC inspects facilities

The Health Facilities Review Committee (HFRC) was established in 1972 as the Hospital Visitors Committee. Its name was changed to HFRC in 1978. It was established under the *Health Facilities Review Committee Act* to assist the Minister of Health and Wellness in maintaining quality care, treatment and Basic Standards of accommodation in health care facilities throughout Alberta.

HFRC is accountable to the Minister of Health and Wellness. HFRC consists of one member of the Legislative Assembly of Alberta and ten private citizens from various urban and rural backgrounds. The HFRC inspects approved mental health centres, acute hospitals and long-term care facilities. The HFRC also receives and investigates complaints into the care and treatment of residents and the Basic Standards of accommodation in a facility. At the end of an investigation, HFRC provides recommendations to the facility and the Authority. HFRC requests that the facility provide an action plan to respond to the recommendations within three months. The Minister also receives a copy of all reports issued by HFRC. The HFRC publishes an annual report of its activities that is available to the public. More information can be found at www.health.gov.ab.ca/hfrc.

Protection for Persons in Care

PPIC investigates complaints

Protection for Persons in Care (PPIC) was established in 1998 under the *Protection for Persons in Care Act* to prevent abuse of adults living in publicly funded facilities by requiring that abuse be reported and investigated. PPIC is accountable to the Minister of Seniors and Community Supports. PPIC investigates reports of abuse involving adults receiving publicly funded care services from hospitals, long-term care facilities, seniors lodges, shelters and group homes. PPIC investigates approximately 90% of abuse complaints using contracted investigators who have backgrounds in health professions and law enforcement. In some cases, referrals are made directly to police authorities or professional associations or colleges. PPIC publishes an annual report on its activities that is available to the public. More information can be found at www.cd.gov.ab.ca/helping_albertans/persons_in_care.

9. Funding for regional health authorities and facilities

Operational funding

Department provides funding to Authorities

The Department provides operational funding to all Authorities to provide acute and ambulatory care, continuing care, home care, health protection, disease prevention and health promotion within their regions. Approximately 90% of this funding is allocated by the Department to Authorities using a population-based formula and the other 10% is allocated for specific purposes or to compensate when there is insufficient data on which to make a population allocation. The Department also provides province-wide services funding to Authorities 3 and 6 for services that are available to all Albertans but only delivered in these two regions, such as bone marrow transplants.

Authorities determine how to allocate funding

Authorities can determine how they allocate the operational funding provided to them by the Department to deliver services within their region. Authorities allocate a portion of this funding to long-term care facilities using a

methodology originally developed by the Department. This methodology distributes available funding based on the number of beds, number of residents and the three-year average CMM of the residents in the facility in relation to other facilities in the region. Each Authority has also customized the methodology to meet its specific circumstances.

Capital funding

Authorities receive capital funding

All Authorities receive funding for capital additions and maintenance projects from provincial capital funds. The Department requires Authorities to develop a Long-Term Capital Plan annually that includes all capital projects of $2.5 million or more. The Plans must identify, justify and prioritize major capital projects needed in the next three years and in the longer term.

Authorities' capital plans include requests for capital funding for long-term care facilities. Nursing homes owned by private corporations or voluntary societies are not eligible to receive provincial capital grants unless the facilities will be developed under an infrastructure partnership agreement between an Authority and the organization. Hospitals owned and operated by voluntary societies under the *Hospitals Act* and having an agreement with the Minister are eligible to receive provincial capital grants. Authorities also receive infrastructure maintenance funding annually to maintain auxiliary hospitals and Authority-owned nursing homes.

10. Determining future needs for continuing care services

In November 1997, the Minister of Health and Wellness initiated a two-year review of continuing care services in the province. A Long-Term Care Policy Advisory Committee was established to guide the review, provide advice on specific issues and develop recommendations for the future.[13]

Broda Report provided recommendations on "aging in place"

The Committee's work resulted in a three-part report, *Healthy Aging: New Directions for Care, November 1999* (often referred to as the Broda Report, after the Committee Chair, Dave Broda), containing a vision, principles and 50 recommendations. The recommendations addressed immediate needs and provided a direction for the future in which individuals would "age in place" in their community—in their home or in supportive housing. Long-term care facilities would be used for individuals with complex and high needs for care.

[13] Department of Health and Wellness, Healthy Aging: New Directions for Care, Part One: Overview, November 1999, p.4

Department required Authorities to prepare plans in response to Broda Report

The Department's response to the Broda Report was released in April 2000, titled *Strategic Directions and Future Actions, Healthy Aging and Continuing Care in Alberta.* This Report contained nine strategic directions, the actions and work the Department would carry out, and what it would require of Authorities. To modify and improve continuing care services and respond to the aging population with the goal of supporting Albertans to "age in place" in the community, the Department required Authorities to prepare Ten-Year Continuing Care Strategic Service Plans that would cover a broad range of continuing care services including a home living stream, supportive living stream, and facility based stream.

RCCM used to help Authorities develop their plans

The Department developed a projection and planning tool, the Regional Continuing Care Model (RCCM), to help Authorities develop their Ten-Year Continuing Care Strategic Service Plans. The model's inputs include population projections, waiting lists for long-term care facility placement, number of hours of service for community care, and current expenditure data. The RCCM allows Authorities to consider seven different scenarios reflecting alternatives for shifting from facility-based services to community services. RCCM provides the Authorities with projected residents and costs to provide care for the different streams—home living, supportive living and long-term care facilities.

Our audit findings and recommendations

Developing and maintaining standards—Recommendation No. 1

We recommend that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Basic Service Standards for services in long-term care facilities

Basic Standards not updated since 1995

The Basic Standards for long-term care facilities cover all the services provided in the facilities including nursing, personal care and housing services. The Basic Standards have not been updated since 1995. At that time, the Department developed the Basic Standards, which incorporated the standards existing in legislation and directives, to provide guidance to the newly created Authorities and the operators of facilities.

Evidence indicates Basic Standards out of date or unclear

During our visits to facilities we saw situations that indicate that the Basic Standards are not up to date. For example, we saw considerable variations in practice among facilities in interpreting the Basic Standard for user fees. We

also found variations in practice in conducting annual physical examinations, managing residents' trust accounts and residents' personal inventories. These variations in practice suggest that either the Basic Standard is out of date or not sufficiently clear to ensure consistent application.

Basic Standard for nursing hours out of date

The Department has also recently indicated that Authorities should increase the number of hours of nursing and personal care that residents in long-term care facilities receive daily to 3.4 paid hours by 2006–07. However, the Department has not changed the Basic Standard of 1.9 hours per resident per day. Also, the Basic Standards require that 22% of the 1.9 hours be provided by registered nurses, certified graduate nurses, or psychiatric nurses. However, LPNs are currently providing approximately 43% of the required nurse hours and the Basic Standards do not contemplate the use of LPNs to meet the requirement for nursing hours.

No Basic Standards for PCAs

There are also no Basic Standards on the competencies and training requirements for personal care attendants, who provide approximately 70% of the care hours in long-term care facilities. This issue is significant because residents of long-term care facilities now tend to have more complex health care needs than before.

Management at Authorities and facilities and many professional organizations also told us that, in their opinion, the Basic Standards were out of date.

Basic care may differ among regions

Authorities may augment Basic Standards as appropriate, and are encouraged by the Department to use them to monitor service delivery. All Authorities have issued guidelines or policies and procedures of their own to either clarify or add to the Basic Standards. This can result in differences from region to region in the level of basic services provided to residents of long-term care facilities. This is appropriate if the levels of services differ in the regions because of the needs and preferences of residents. However, differences arising as a result of Authorities supplementing Basic Standards with their own guidelines or policies and procedures can result in differences in basic care among the regions.

Review of the Basic Standards

No process to review the Basic Standards

The Department does not have a process to periodically review the Basic Standards to ensure that they reflect current policy and care needs of residents. The Department does not seek input from the Authorities, facility operators or various health care professional groups to identify changes required to the Basic Standards. Professional organizations that we met during our audit told us that the Department has not asked them for feedback on the Basic Standards.

The Department does not have a process to identify incidents or trends in delivery of services that may indicate that the Department should intervene and issue a new Basic Standard or update a current Basic Standard. Sources of information that could influence changes needed in Basic Standards are reports released from the HFRC, and the monitoring of complaints by Authorities. The Department does not have a mechanism to incorporate findings from these processes into updated Basic Standards.

Other than Authorities 4 and 7, the other seven Authorities regularly review their internal guidelines, policies and procedures to ensure that they are current and relevant.

Public disclosure of Basic Standards

Basic Standards not readily available to the public

The Department makes the Basic Standards available to those individuals that request them but they are not readily available, and Authorities are not required to advise residents of the Basic Standards. Stakeholder groups informed us that residents and family members of long-term care facilities were not familiar with the Basic Standards, and therefore, were unsure of the level of basic services that they should expect at the facilities. They indicated that it would help them if the Department made the Basic Standards readily available to the public.

Implications and risks if recommendation not implemented

Residents may not receive appropriate care

Without current Basic Standards, residents of long-term care facilities may not receive appropriate nursing, personal care or housing services. Basic Standards alone will not guarantee appropriate care and services for residents. However, they guide caregivers about the basic level of care and services to provide to residents.

Compliance with Basic Service Standards—Recommendation No. 2

We recommend that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Monitoring and reporting compliance and inspecting facilities

No adequate systems in place to monitor compliance with Basic Standards

The Department and Authorities do not have adequate systems to monitor compliance with Basic Standards in long-term care facilities. The Department relies on the Authorities, the Health Facilities Review Committee (HFRC) and the Protection for Persons in Care Office (PPIC) to monitor facilities' compliance with the Basic Standards. However, the Authorities, HFRC and PPIC

do not provide the Department with sufficient information to determine whether all the Basic Standards have been complied with.

31% of Basic Standards relating to care not met by facilities we visited

During our facility visits, we noted that 31% of the Basic Standards relating to care were not met. Some significant findings from our 25 long-term care facility visits, as outlined in Appendix B, are:

- At over half of the facilities we saw inconsistencies in the application and recording of the use of chemical and physical restraints on residents.
- Only 7 of 25 facilities fully met the Basic Standards for the administration and management of medication to residents.
- Resident care plans were not always updated or monitored to determine whether care outcomes are being achieved.
- Approximately half of the facilities we visited did not ensure that residents received annual medical assessments from physicians.

Most Authorities do not inspect facilities for compliance with all the Basic Standards

The Department does not require Authorities to inspect facilities and report to the Department on compliance with the Basic Standards. Most Authorities do not have any processes in place to monitor whether their facilities comply with all the Basic Standards. Authority 8 recently began to conduct operational reviews of its facilities to determine whether they are complying with the Basic Standards. Authorities 3 and 6 perform reviews of matters arising from public health inspections, pharmacy reviews and quality reviews; however, these inspections and reviews focus on some, but not all, of the Basic Standards. The other six Authorities make informal visits to facilities and may conduct a review to resolve a critical incident brought to their attention. The Department relies on reviews by HFRC and PPIC and the accreditation process to provide assurance that the Basic Standards have been followed. However, there are factors that limit the effectiveness of accreditation, HFRC and PPIC, as discussed below.

Accreditation

Accreditation not sufficient

Accreditation provides some assurance that facilities are complying with the Basic Standards; however, accreditation alone is not sufficient to monitor whether Basic Standards are being complied with because it:

- applies to the Authority but not to individual facilities.
- is voluntary, both at the regional and facility level; an Authority could be accredited without having all facilities in the region participate in the process. In Authorities 2 and 8, we noted that all non-region owned long-term care facilities are not included in the process.
- does not cover all the Basic Standards.
- is primarily a self-assessment process.

Health Facilities Review Committee

HFRC reviews not sufficient

HFRC does not conduct compliance or regulatory reviews. HFRC reviews provide some compliance monitoring, but the reviews are not sufficient because:

- the Committee does not check for compliance with all Basic Standards. Its processes do not contemplate areas covered by Basic Standards, such as provision of minimum care hours, frequency of physician assessments, therapeutic diets, maintenance of health records and care plans, user fees and trust accounts.
- the provisions of the *Health Facilities Review Act* specifically prohibit the review by committee members of medical records without the resident's consent, and financial records. Their reviews are primarily qualitative based assessments concerned with the dignity and satisfaction of residents and families.
- members are not required to have medical training.
- the Committee has no authority to enforce compliance. There are no sanctions specified in the *Health Facilities Review Act* for facilities or regional health authorities that fail to implement recommendations following an investigation by the Committee.

Protection for Persons in Care

PPIC investigations not sufficient

PPIC completes investigations based on complaints of abuse from residents, family, facility staff or others in a number of settings, including long-term care facilities. PPIC provides only limited assurance of compliance with Basic Standards because:

- PPIC responds to abuse complaints only; they do not initiate reviews and are prohibited by their Act from reviewing residents' medical records without consent, or facility records on financial matters.
- PPIC does not conduct compliance or regulatory reviews in long-term care facilities for the Basic Standards, policies, procedures or legislation. However, if they uncover evidence of a facility's failure to meet the Basic Standards, policies or legislation, they will include appropriate recommendations in their reports.

Monitoring and investigating complaints and incidents

Department does not require information on complaints and incidents from Authorities

The Department has an effective process to assess and investigate complaints that it receives about continuing care services in long-term care facilities. However, the Department does not require Authorities to forward any information, such as trends in the number and nature of complaints and incidents.

Authorities do not receive consistent information on complaints and incidents

Authorities have systems to assess, investigate and monitor complaints and incidents that are reported to them, but not all Authorities have defined what a critical incident is, and Authorities do not receive consistent information on complaints and incidents from facilities. Also, each Authority determines what it reports to the Department about critical incidents.

The Minister expects that Authorities will rectify problems from incidents and complaints. All Authorities promptly assess and investigate the complaints and incidents reported to them by the facilities, as well as the complaints that Authorities receive directly. Authorities differ in the amount of information that they require to be reported to them on complaints and incidents. In some cases, Authorities receive information on the number and nature of complaints and incidents from owned facilities and critical incidents from contracted facilities; in others, the Authorities require only critical incidents to be reported to them. Authorities 7 and 9 have not defined a critical incident, even though Authority 7 requires critical incidents to be reported to them. Authority 2 does not require contracted facilities to report incidents to them.

All Authorities monitor complaints and incidents reported to them

All Authorities have systems to monitor trends in the number and nature of complaints and incidents reported to them. Because there is no formal directive from the Department of Health and Wellness on communicating complaints and reportable incidents, Authorities report complaints and incidents to the Department at their discretion.

Implications and risks if recommendation not implemented

Residents may not receive appropriate care

If facilities are not monitored for compliance with Basic Standards, the Department and Authorities will not know if facilities are complying with Basic Standards. As a result, residents may not receive appropriate care or services.

Effectiveness of services in long-term care facilities—Recommendation No. 3

We recommend that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, assess the effectiveness of services in long-term care facilities.

Recommendation No. 4

We recommend that the Department of Health and Wellness, working with the Department of Seniors and Community Supports, collect sufficient information about facility costs from the Regional Health Authorities and long-term care facilities to make accommodation rate and funding decisions.

Performance information

Department does not collect information on quality of care

The Department does not collect information on the quality of care and services provided to residents in long-term care facilities. The Department and the Authorities have agreed to implement the Minimum Data Set (MDS) system, an information system that will provide quality of care indicators for each long-term care facility resident. The 24 quality indicators in MDS measure the quality of life and health of residents. In addition, the Department and the Authorities have developed other quality measures to track in the MDS system. When all Authorities report MDS data, the Department will have information to assess the quality of care and services provided to residents. The Department and Authorities will then be able to compare results by region and facility and to other provinces. This will enable the Department and Authorities to set benchmarks for quality of care and services in the province. The Department and Authorities plan to implement this system by the fiscal year 2007–08.

Amount and type of information Authorities collect varies

Although all Authorities collect quality of care information from facilities in their region, the amount and type of information varies among the Authorities, and in some cases, it varies depending on whether the facilities are owned or contracted. Authority 1 has already implemented MDS for its owned facilities and uses the quality indicators to evaluate the facilities' performance. Authorities 3, 4 and 6 require all of the facilities in their regions to report on a comprehensive set of quality indicators. No Authorities report quality indicators to the Department.

Once the Department and Authorities have sufficient information about the quality of services provided in the facilities, they will be able to link costs to the results of long-term care services and measure the cost-effectiveness of the services.

Cost information to support funding decisions

Department and Authorities collect information to make funding decisions

The Department collects information about the cost of long-term services primarily to make funding decisions. The Authorities also collect cost information to monitor facility expenditures against budgets, identify significant changes in facility revenues and expenses, and make funding decisions.

Cost estimates to support funding decisions not current

The Department uses cost estimates for each of the A to G resident classifications in allocating a portion of the operational funding to Authorities and to charge regions for services provided to residents of other regions. The Department determined the cost estimates in 1998–99 and adjusts the estimates annually with an inflation factor. The Department does not have any current information to determine whether the cost estimates for resident classification categories are reasonable.

Actual costs approximately 29% higher than cost estimates used by Department

We tested the cost estimates for the resident classifications for reasonability by using them to estimate expenditures for the 2001–02 year. Actual costs were approximately 29% higher than the number produced by the cost estimates. This means that, to the extent that resident classifications vary among Authorities, there may not be an equitable allocation of funds to Authorities. The Department needs to update the cost estimates to ensure the accuracy of the allocation of funds to Authorities.

No tool to measure medical care needs, only functional care needs

The Department and Authorities use resident classifications to predict the extent of functional care needs for residents that would typically be provided by personal care attendants in a facility. Although there may be some correlation between functional and medical care needs in some residents, there is no existing tool to measure specific overall medical care needs and predict the extent of clinical intervention by health professionals that may be required. The classifications may not be as useful in predicting needs for physician, pharmacist, nursing, dietician, rehabilitation and other medical services, including expensive medical technologies. However, once MDS is implemented, better data should be available to assess both functional and medical care needs. This information will be useful in making funding allocations to Authorities and facilities.

Funding for facilities varies by up to $10,000 per bed per year among regions

All Authorities fund their contracted long-term care facilities based on the funding methodology the Department used before regionalization to fund facilities. The Authorities customized it. Facility funding levels differ among the Authorities; funding varies by up to $10,000 per year per bed. While we expected some differences in funding levels between the regions due to things like differing resident functional care needs, staff mixes, funded rates per hour for nursing time, and number of funded paid hours per resident day, we were unable to obtain information to explain the large range in funding. Also, since information about the quality of services achieved by each region was not available, we could not assess if the Authorities that spend more achieve better results than the Authorities that spend less.

Cost information to support accommodation rates in long-term care facilities

Department does not have information to assess whether accommodation rates sufficient

The Department of Health and Wellness does not require Authorities or facilities to report long-term care facility costs in sufficient detail to enable it to assess whether accommodation rates are sufficient to cover accommodation costs. The Department also does not have a policy on the portion of accommodation costs that are the responsibility of the resident, what accommodation costs should consist of, or how to calculate the accommodation rate.

Because the Department did not have any accommodation cost information from Authorities or facilities, the Department had to use information provided by other organizations to determine the August 1, 2003 accommodation rate increase. Specifically, the Department obtained information on facility costs from the Alberta Long-Term Care Association, it obtained comparable information on lodge costs from the Department of Seniors, and it surveyed other provinces for their accommodation rates.

Implications and risks if recommendation not implemented

Funding may not be allocated effectively, and residents may not be paying appropriate accommodation costs

The Department and Authorities need information about the quality of services provided in long-term facilities to make informed decisions about the effectiveness of various initiatives to improve services. Without this information, the Department may not effectively allocate funds to Authorities and facilities. The Department also needs better information about facility costs to ensure accommodation rates cover accommodation costs. Residents may not be charged an appropriate amount for accommodation costs.

Information to monitor compliance with legislation—Recommendation

We recommend that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, identify the information required from long-term care facilities to enable the Departments and Authorities to monitor their compliance with legislation.

Responsibilities of the Department and Authorities

Responsibilities clearly defined

The responsibilities of the Department and the Authorities for services in long-term care facilities are clearly defined in the *Regional Health Authorities Act*, *Hospitals Act*, *Nursing Homes Act* and *Public Health Act*, related regulations and policy directives.

Accountability framework between Department and Authorities

In April 2004, the Department established a new accountability framework that requires Authorities to submit a three-year health plan and an annual business plan and report against these quarterly and annually. We could not assess the effectiveness of the framework because it was established for the 2004–05 fiscal year and Authorities will not start annual reporting until July 2005.

Accountability framework between Authorities and facilities

Most Authorities have set out clear responsibilities

All Authorities require facilities to comply with legislation and have systems in place to ensure that facilities operating in their region are aware of their responsibilities for services in long-term care facilities. Most Authorities have contracts or service expectations letters that set out clear responsibilities; however, two agreements with facility operators that we examined had expired or did not clearly define responsibilities.

Most Authorities do not require sufficient information from facilities

The contracts or agreements vary significantly among the Authorities and often do not require sufficient management information to be reported by facility operators to enable the Authorities to adequately monitor the contracted facilities. Authorities 3, 4 and 6 require comprehensive reporting from all of their facilities on matters such as critical incidents, performance indicators (quality of care and financial) complaint management, drug requests, accreditation status, workforce data, insurance information, inspection reports—fire, maintenance and cost. However, only Authorities 3 and 6 have set performance targets for the indicators and the requirement to report on results for all of the facilities in their regions. The other Authorities require some financial information and a few quality indicators to be reported to them.

Department's systems to monitor compliance with legislation

Department does not receive sufficient assurance that facilities comply with legislation

The Department's systems to monitor compliance with acts, regulations, directives and policies for services in long-term care facilities do not provide sufficient assurance that legislation is complied with. The Department reviews new contracts that Authorities enter into with facilities to ensure that facilities have not been exempted from any legislated requirements.

The Department also attempts to monitor compliance with legislation through assertions by Authorities' boards and management in their health plans and annual reports. However, when we reviewed these documents, we could not find any assertion by the boards and management that Authorities have complied with all applicable legislation.

Authorities' systems to monitor compliance with legislation

Authorities do not receive sufficient assurance that facilities comply with legislation

All Authorities receive some information from facilities to help them identify potential non-compliance with legislation; however, no Authorities have a system to monitor whether facilities comply with legislation. In addition, Authorities do not receive any written assurance from contracted facility operators that they have systems to ensure they comply with legislation. The Authorities also do not report on compliance with legislation to the Department because they are not required to do so.

Implications and risks if recommendation not implemented

Residents may not get service they require

The Department and Authorities need assurance that facilities meet legislated and contractual requirements, which are ultimately intended to ensure residents' needs are met. Without this assurance, the Department and Authorities will not know if legislated and contractual requirements are being met, and residents may not get the service required.

Determining future needs for services in long-term care facilities—Recommendation No. 5

We recommend that the Department of Health and Wellness, working with Regional Health Authorities and the Department of Seniors and Community Supports, develop a long-term plan to meet future needs for services in long-term care facilities. We also recommend that the Departments publicly report on progress made towards goals in the plan.

We recommend that the Department of Health and Wellness require Regional Health Authorities to periodically update and report on progress implementing their Ten–Year Continuing Care Strategic Service Plans.

Systems to determine future needs

There are systems in place to project future needs

The Department and Authorities currently have projections to 2030 for the number of individuals and beds required to meet the needs for supportive living and long-term care facilities. The Department and Authorities have systems to collect data and a model to project future needs for services. The Department and Authorities use a model developed by the Department to project future needs for services and capital requirements. In some cases, Authorities have altered the model to meet their particular needs.

Strategies to meet future needs

One recommendation in the Broda Report was to reduce the number of people relying on long-term care facilities and increase the number using supportive living settings. Therefore, strategies to meet long-term care needs should be developed in conjunction with strategies to meet supportive living needs.

Several issues affecting future needs for long-term care services

There are also a number of issues affecting the delivery of services in long-term care and supportive living settings that the Department and Authorities need to respond to. These include:

- An aging population will increase the demand for services and facilities.
- Residents of long-term care facilities have increasingly complex care needs.
- The long-term care workforce is aging and it is currently hard to recruit medical professionals to work in long-term care facilities.

No long-term plan to meet future needs

The Department does not have a long-term plan to meet future needs for services in long-term care facilities and supportive living settings. The Department developed nine strategic directions in response to the Broda Report but did not develop a plan to achieve these strategic directions. Instead, the Department asked the Authorities to prepare ten-year plans to implement the nine strategic directions. All Authorities projected their future needs, and included strategies to meet those needs in their Ten-Year Continuing Care Strategic Service Plans (2002–2012). The Plans aligned with the nine strategic directions established by the Department. However, the Department does not have a comprehensive plan to ensure that the nine strategic directions will be achieved.

Department does not receive sufficient information from Authorities to assess progress on their ten-year plans

The Department also does not receive sufficient information from Authorities to fully assess Authorities' progress in meeting the goals set out in their ten-year plans. All Authorities now include some of the goals included in their ten-year plans in their three-year health plans and annual business plans. They have also reported to the Department in their Annual Report on their progress against those goals. However, Authorities do not report to the Department on their progress in meeting all the goals in their ten-year plans. As a result, the Department does not receive sufficient information from Authorities to assess progress on the nine strategic directions.

In addition, some Authorities have not updated their ten-year plans to reflect recent boundary changes. Because of this, the plans do not necessarily tie to the Authorities' current capital plans.

Monitoring and reporting

Department obtains information to assess whether current needs being met

The Department obtains some information to determine the extent to which current needs for long-term care facilities are being met. The Department measures the ratio of the number of long-term care beds to the population over age 75 and compares the results to a provincial target to evaluate whether the shift from long-term care facilities to supportive living is taking place. The

Department tracks this information for each region and the province. The Department also evaluates if needs are being met by tracking the changes in the number of individuals waiting for a long-term care bed. The Department sets annual targets for wait lists in its business plan and compares the wait list information provided by the Authorities to the Departmental targets.

Starting in the fiscal year 2005–06, the Department will require Authorities to measure and report the number and type of investments in supportive living arrangements, including designated assisted living and home care, and the proportion of services provided through community home care. The Department plans to evaluate these measures against the targets established by each Authority.

Implications and risks if recommendation not implemented

Long-term needs for services may not be met

In the absence of a provincial long-term plan for services provided in long-term care facilities, Authorities may not have adequate direction. Planning may be fragmented and strategies, goal and results will not be assessed comprehensively on a province-wide basis. As a result, long-term needs for services in long-term care facilities may not be consistently met.

Services in supportive living settings

Conclusions

We have identified that there are no standards for the care and housing services provided in assisted living and other supportive living facilities—see page 45.

Standards for operating lodges are not current and the Department of Seniors and Community Supports (the Department) does not have systems in place to know whether lodge operators are complying with the Seniors Lodge Standards—see page 48. We also found that the Department needs to obtain information to assess the effectiveness of the program and to determine whether the current minimum disposable income set for residents of lodges is appropriate—see page 49. The Department needs to improve its process for identifying the increased care needs of lodge residents and incorporating this information in its plans for the Seniors Lodge Program—see page 50.

Background

Increasing number of supportive living settings

The future direction for continuing care services as set out by the Broda Report and supported by the Departments and Authorities is a shift in the delivery of continuing care services from long-term care facilities to supportive living settings. To achieve this shift, long-term care facilities would focus on those individuals with the highest and most complex care needs and supportive living settings would provide services for seniors who have fewer care requirements. The Departments and Authorities have started to implement this shift and the number of supportive living settings that provide services to seniors is increasing.

Supportive living settings provide various levels of assistance to seniors who do not need the 24-hour nursing and personal care services provided in a long-term care facility. Supportive living facilities may be operated by publicly funded non-profit organizations, private non-profit organizations or for-profit companies. Unlike residents of long-term care facilities, residents of supportive living facilities must purchase their own medication and medical supplies.

Seniors can access several types of supportive living settings to meet their housing and care needs:

1. Assisted living—there are several assisted living models. Typically, this supportive living setting provides residents with nursing care services in addition to housing and personal care services. These facilities often serve residents who have more complex needs than would typically be provided for in other supportive living settings. Designated assisted living facilities are those facilities where Authorities and an owner have a contractual relationship for coordinating and providing continuing care services in the facility.

2. Lodges—these are designed to provide room and board for seniors who are functionally independent. Core services provided in lodges include basic room furnishings, meals, housekeeping services, linen services, security, 24 hour non-medical staffing and life enrichment services. Some lodges may provide enhanced services such as personal care, medical assistance and contracted home care services based on the needs of the residents; these facilities are known as Enhanced Lodges. Enhanced Lodges are similar to assisted living facilities except that they serve residents who have less complex needs than those in assisted living. Any medical care provided to a resident of a lodge is provided by an Authority through home care services.

3. Other supportive living settings—these facilities, such as seniors complexes and group homes, provide seniors with private living accommodation, a safe environment, 24-hour monitoring and emergency response, options for meals, housekeeping, transportation, social and recreational activities and some basic living and personal care services. These facilities are typically operated by non-profit or profit organizations without any government involvement.

As at March 31, 2004, the most current information the Department of Health and Wellness had on supportive living settings where the Authorities provide continuing care services was:

- Designated Assisted Living Facilities – 1,033 beds
- Other assisted living facilities – 552 beds
- Enhanced Lodges – 307 beds

There are also 143 lodges, with approximately 8,500 beds, in the province. The Department of Seniors and Community Supports estimates that at April 2005 there are approximately 10,000 other supportive living beds; however, because some of these facilities do not have contracts with the Departments or the Authorities to provide services in these settings, the number may not be complete.

Assisted living and other supportive living settings

Our audit findings and recommendations

Standards for services in assisted living and other supportive living settings—Recommendation No. 6

We recommend that the Department of Health and Wellness and the Department of Seniors and Community Supports establish standards for care and housing services provided in assisted living and other supportive living settings.

No minimum standards for supportive living

There are no minimum standards for housing, nursing and personal care services provided in assisted living and other supportive living settings. In the absence of standards, the Department of Health and Wellness is using the standards set for home care but these standards do not cover the full range of care services provided in these settings and do not deal with personal care or housing services. There is also no commonly accepted definition of what services should be provided in supportive living settings and who is responsible for the cost and delivery of these services. The costs paid by residents of the facilities also vary and while this may be acceptable, residents do not have sufficient information to compare each facility because the services vary significantly.

The groups that we met with during our audit stated that clarity on the services and the standards provided in supportive living settings would be useful. Authorities also indicated guidance would be helpful.

Implications and risks if recommendation is not implemented

Residents may not receive appropriate care or services

Without standards specific to the services provided in assisted living and supportive living settings, residents may not be receiving an appropriate level of continuing care, housing or personal care services.

Seniors Lodge Program

Background

Functionally independent seniors eligible for lodge accommodation

The Department of Seniors and Community Supports provides a number of social housing programs, including the Senior Lodge Program that provides lodge accommodation to eligible seniors. Seniors are eligible for lodge accommodation if they are functionally independent on their own or with the assistance of existing community-based services. The Department estimates that the average age of residents in lodges is about 84 years, and that 75% of lodge residents receive home care.

Management bodies operate lodges

There are 143 lodges in the province operated by management bodies. Management bodies are either private or not-for-profit organizations that manage social housing projects including lodges. There are currently 135 management bodies in the province, 64 of which operate lodges. Management bodies are responsible for managing the lodge operations and selecting tenants.

Management bodies set lodge rates

Management bodies set lodge rates. Rates may vary between regions and lodges depending on the services provided. However, to protect lower income residents, management bodies must ensure that senior residents are left with at least $265 monthly in disposable (after tax) income to spend on personal needs after paying their basic monthly lodge rent.

The responsibilities of management bodies are set out in legislation (the *Alberta Housing Act*, *Management Body Operation and Administration Regulation*, among others) and the Department's Management Body Handbook. Some key management body responsibilities include:

- operating the housing accommodation efficiently and providing the accommodation to those persons in greatest need.
- preparing and submitting to the Department annual budgets, three-year business plans and audited financial statements.
- calculating rent in accordance with legislation.
- developing policies and programs in accordance with legislation.

Seniors Lodge Standards developed in 1996

The Standards for the Operation of Seniors Lodges (Seniors Lodge Standards) were developed in 1996 by the Lodge Standards Working Group, a group composed of members from the Alberta Senior Citizens' Housing Association (ASCHA) and the Department of Community Development (now Seniors and Community Supports). The Minister and the ASCHA board representative approved the Seniors Lodge Standards. Lodges that chose to undergo a lodge review and demonstrated compliance with the Seniors Lodge Standards received certification. The Standards cover the following:

- Housing services
- Meal services
- Laundry services
- Housekeeping services
- Service and care coordination (including medication assistance)
- Life enrichments and social supports
- Lodge operations
- Education of staff
- Safety and security

The operations of the lodges are funded by:

- accommodation charges
- the Department's Lodge Assistance Program grants
- municipalities that fund the operating deficits of the lodges

Department provides capital grants to management bodies

The Department also periodically provides grants to management bodies to meet the requirements for constructing additions to existing lodges and constructing new lodges. The Department funds up to 50% of the total capital costs and management bodies and municipalities fund the rest.

Department provides a daily grant for each low and moderate income senior

Under the Lodge Assistance Program, the Department provides financial assistance to management bodies with a daily grant for each low and moderate income resident. The Department's grant is based on eligible tenants per lodge (daily rate of approximately $5.50 per day per tenant up to December 31, 2004 and $6.50 per day per tenant effective January 1, 2005). Eligible residents are those whose income as stated on line 150 of their personal income tax return is equal to or lower than the Lodge Assistance Grant Income Threshold, which is $27,120 for 2005–06.

The trend in waiting lists for seniors lodges in Alberta is as follows:

Table 6 – Vacancy rates and waiting lists for seniors lodges[14]

	Number of units	Vacancy rate	Waiting list
March 2002	8,008	3.96%	3,190
March 2003	8,185	3.62%	3,345
March 2004	8,479	3.51%	2,485
September 2004	8,567	4.87%	2,380

[14] Department of Seniors and Community Supports

Our audit findings and recommendations

Developing and monitoring standards for the Seniors Lodge Program—Recommendation No. 7

We recommend that the Department of Seniors and Community Supports:

1. **update the Seniors Lodge Standards and implement a process to maintain them.**
2. **improve its systems to monitor management bodies' compliance with the Seniors Lodge Standards.**

Compliance with Seniors Lodge Standards voluntary

The Department is responsible for providing financial assistance to management bodies that provide lodge accommodation and for ensuring that management bodies operate in accordance with legislation. The roles and responsibilities of management bodies are set out in legislation and clarified in the management body handbook. In addition, the Department encourages lodge operators to comply with the Seniors Lodge Standards. However, compliance is voluntary and not in legislation or the management body handbook.

Seniors Lodge Standards out of date

Although there was a process to review and update the Seniors Lodge Standards annually, this process has not been followed. The current Seniors Lodge Standards are out of date and ASCHA and the Department are working to update them. There is agreement in the industry that the current Seniors Lodge Standards lack relevance to the range of services now being demanded in lodges. The current review includes consideration of personal care and health care services that may be provided in lodges.

Sixteen management bodies that we reviewed had their own standards in addition to the Seniors Lodge Standards. The management bodies' standards and policies, do not contravene the Seniors Lodge Standards or any legislation, but simply augment them.

No system to monitor compliance with Seniors Lodge Standards

The Department does not currently have a system to monitor compliance with the Seniors Lodge Standards. No lodge reviews have been performed since 2002. The reviews have been suspended while the standards committee develops new standards. The Department expects lodge reviews to resume in the fall of 2005. However, those lodges that decide not to participate in ASCHA also do not participate in the related lodge review process. We noted one instance, out of twenty examined, of a management body that had opted out of ASCHA membership and the lodge review process.

10 of 20 management bodies have system to deal with complaints

The Department expects management bodies to deal with complaints and incidents and only expects to become involved in complaints that have not been adequately dealt with by the lodge operators. Ten of the 20 management bodies we reviewed have a complaint system in place, including a process to receive and document complaints.

6 of 20 management bodies have system to monitor their compliance with legislation and policies

Six of the 20 management bodies have their own internal review process to monitor their compliance with legislation and policies, however, these inspections do not cover all Seniors Lodge Standards. The management bodies do not report the findings from these internal processes to the Department. Nor does the Department require management bodies to report on compliance with legislation or Seniors Lodge Standards.

Implications and risks if recommendation is not implemented

Without current and relevant standards for care and services in lodges, residents may not be receiving appropriate services.

Effectiveness of Seniors Lodge Program—Recommendation No. 8

We recommend that the Department of Seniors and Community Supports:

1. **improve the measures it uses to assess the effectiveness of the Seniors Lodge Program.**
2. **obtain sufficient information periodically to set the minimum disposable income of seniors used as a basis for seniors lodge rent charges.**

The Department has not identified a specific objective for the Seniors Lodge Program but has identified a goal in its business plan that is meant to be applied to all forms of housing, including lodges. The Department's goal is that provincially owned and supported housing is efficiently and effectively managed and appropriately used.

Information Department collects not sufficient to assess if goal met

The Department measures and reports on the percentage of lodge residents who are satisfied with the quality of their accommodation in its annual report. The Department also obtains waiting list information from management bodies semi-annually and obtains budgets and financial statements annually. However, this performance measure and information are not sufficient to determine whether the Department is adequately meeting its goal for the Seniors Lodge Program. The Department has only limited information on the quality of services provided in the lodges.

Department does not assess whether the $265 monthly disposable income rate set in 1994 is still appropriate

The Department does not periodically obtain and review information to assess whether the monthly disposable income rate for lodge residents is appropriate. The monthly disposable income for lodge residents was set in 1994 at $265 per resident. This monthly disposable income has never been adjusted to reflect lodge residents' increasing personal income requirements due to increased care needs and inflation. The Department has not obtained information on the current living costs of seniors to analyze whether the rate set in 1994 is still appropriate and if a change to the disposable income rate is required. In our opinion, the Department does not evaluate the residents' disposal income rate annually.

Department adjusts daily grants periodically

The Department periodically reviews and adjusts the daily operating grant provided to lodges under the Lodge Assistance Program. The Department compiles the financial information from all the management bodies with provincially-supported lodge operations in a financial summary report that includes information on revenues, expenses and net operating results. The Department uses the financial summary report to assess whether the daily grant is sufficient to cover approximately 50% of the lodge's net operating costs. The remaining 50% of the net operating costs is funded by municipalities. The financial summary report is also circulated to management bodies as a basis for them to compare their costs against other lodge operators.

Eighteen of the twenty management bodies examined in our sample performed cost analysis and used the information to prepare business plans and set user charges; two management bodies did not perform any cost analysis. Management bodies that perform cost analysis do not report it to the Department.

Implications and risks if recommendation is not implemented

Without better information Department can't determine if changes needed

Without better information on the effectiveness of the Seniors Lodge Program and the appropriateness of the minimum disposal income rate, the Department cannot determine whether changes are required to achieve the program goals.

Determining future needs—Recommendation

We recommend that the Department of Seniors and Community Supports improve its processes for identifying the increasing care needs of lodge residents and consider this information in its plans for the Seniors Lodge Program.

Department projects future lodge requirements

The Department includes future lodge requirements in its request to the government's capital planning initiative committee for grant funding for construction and upgrading of lodges. The Department projects the future lodge requirements for the Seniors Lodge Program using current information from management bodies on the number of lodge units, vacancies, and waiting lists. The Department estimates that 734 units are required per year for the next ten years to meet the needs of low and moderate income seniors. The Department's September 2004 request for grant funding for lodge construction was $199 million (50% of the total costs).

Department's cost estimate may not be adequate

The Department's request includes estimates of the construction costs of the new units based on historical costs and includes a 3% inflationary increase in the cost of construction per year. However, the estimated cost to construct the required lodge units in the request may not be adequate given the increasing level of care and housing services required by residents of the facilities. The Department's projections of future needs do not reflect new requirements such as the capacity to provide the increased health care and personal care services that lodge residents may require in the future. The Department does not obtain and incorporate information, such as projected home care needs or personal care needs, from management bodies, municipalities, Authorities, or the Department of Health and Wellness in its projections to determine the facilities required to meet the future service needs and the estimated costs of these facilities. The request also did not include the estimated increase in annual Lodge Assistance program grants to support these new facilities.

Legislation requires management bodies to prepare and submit three-year business plans to the Department of Seniors and Community Supports annually. Nine of the twenty management bodies we examined conduct their own forecasting of future needs and incorporate it into their business plans. Seven performed limited planning, related primarily to short-term capital and maintenance needs. Four did not prepare a business plan at all.

Implications and risks if recommendation is not implemented

May not meet needs of future residents

Without adequate information on the needs of seniors in lodges, the Department's plans for the Seniors Lodge Program may not adequately provide for the cost of meeting the needs.

Alberta Seniors Benefit Program

Conclusions

The Department of Seniors and Community Supports needs to improve the information used to:

1. measure whether the Alberta Seniors Benefit Program (ASB) objective is being achieved—see page 55.
2. set the income thresholds, cash benefit, and supplementary accommodation benefits for the program—see page 56.

Background

Alberta Seniors Benefit Program provides cash benefits to seniors

The Minister of Seniors and Community Supports is responsible for administering the Alberta Seniors Benefit Program. The ASB is an income-based program that provides cash benefits to eligible seniors. ASB provides support to seniors in addition to federal benefits received under Old Age Security, Guaranteed Income Supplement, Federal allowances and the Goods and Services Tax Credit. Seniors are eligible to receive maximum ASB benefits if they are over 65 and receive the full amount of Old Age Security benefit. Seniors not receiving old age security benefits are eligible to receive ASB at a reduced rate.

Benefit amounts depend on income and are not taxable

The amount of ASB benefit received by the senior depends on income, Old Age Security eligibility, marital and cohabitation status and residence type. The lower a senior's income, the higher their benefits will be, up to the maximum. ASB benefits are not taxable. Although seniors must report the amount received as income, they can deduct it when calculating federal and provincial taxable income.

ASB is designed to help seniors pay for the necessities of life, but is not meant to help those in financial distress. Seniors in financial distress may receive financial assistance, of up to $5,000 per year, from the Special Needs Assistance Program.

In general, eligible seniors who meet the income tests receive a monthly cash benefit, up to the maximum annual amount. The following table shows the maximum benefits as of July 2004.

Table 7 – Maximum benefits under ASB as of July 2004[15]

	Residence category	Effective July 2004
Single seniors Annual income threshold $15,505 or less		
Maximum cash benefits	Renter, lodge, or homeowner	$2,880
	Long-term care facility	$7,335
	All other residence categories	$1,860
Senior couples Annual income threshold $22,010 or less		
Maximum cash benefits	Renter, lodge, or homeowner	$4,320
	Long-term care facility	$8,775
	All other residence categories	$3,720

All other residence categories refers to seniors who live with relatives or belong to religious communities (for example, Hutterite colonies), where they receive accommodation "rent-free." Seniors in supportive living settings are included as "Renters."

The number of seniors receiving ASB in each age group as at January 2005:

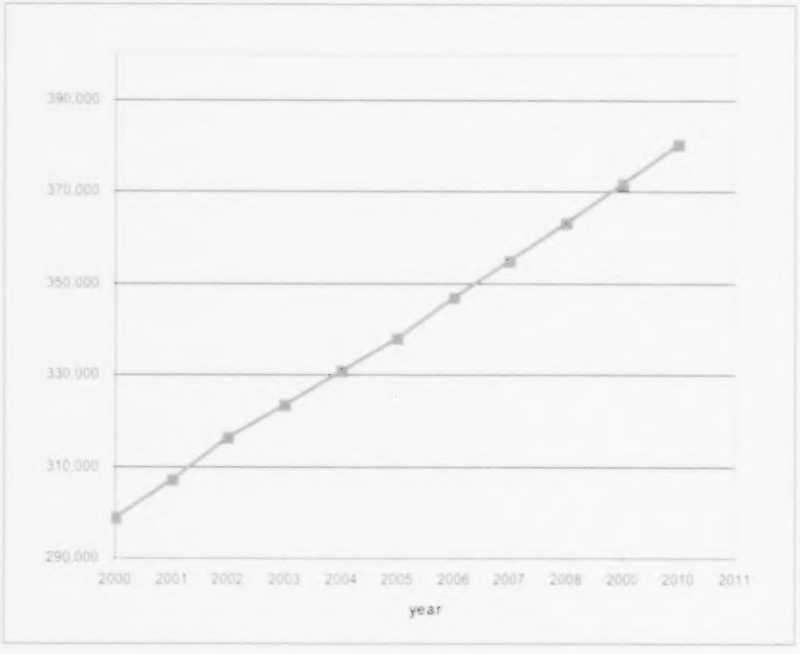
Table 8 – Number of seniors receiving ASB[16]

Age group	Number of seniors
65	4,945
66–69	24,905
70–74	33,128
75–79	30,465
80–84	24,535
85–89	15,343
90+	9,466
Total	142,787

[15] Department of Seniors and Community Supports
[16] Department of Seniors and Community Supports

The following graph shows the projected number of seniors in Alberta to 2010 based on recent trends:

Chart 3 – Projected number of seniors in Alberta[17]



Our audit findings and recommendations

Effectiveness of the Alberta Seniors Benefit Program—Recommendation
We recommend that the Department of Seniors and Community Supports improve the measures it uses to assess whether it is meeting the objective of the Alberta Seniors Benefit Program.

The Department has defined the objective of the ASB; it is to provide financial support to seniors in need. The objective has not changed since the program began. The Department's goal for the ASB is: "*Seniors in need have access to financial supports that enable them to live in a secure and dignified way.*"

The Department has two performance measures to evaluate whether it is achieving its goal for the ASB:

- percentage of eligible seniors provided with the opportunity to apply for the Alberta Seniors Benefit
- the satisfaction of seniors with information provided

[17] Data from the Alberta Seniors Benefits database, Department of Seniors and Community Supports

Department does not measure whether ASB objective achieved

These measures give the Department information on access to the program and user satisfaction with program information. However, the Department does not directly measure whether the objective of ASB is achieved. The Department has not defined "need" and does not measure whether the ASB is sufficient to meet the needs of seniors. The Department views ASB as an income supplement to federal benefits that is not designed to meet all of a senior's financial needs, so the Department does not evaluate the program based on assessed need.

Implications and risks if recommendation not implemented

Without sufficient measures, the Department cannot assess whether it is meeting the program objective.

Information to determine program benefits—Recommendation No. 9

We recommend that the Department of Seniors and Community Supports obtain further information necessary to make income threshold, cash benefit and supplementary accommodation benefit decisions for the Alberta Seniors Benefit Program.

Department does not assess adequacy of income thresholds and cash benefits

The Department obtains information on current costs of the ASB and the effect of changes to related federal benefit programs on the ASB. However, the Department does not obtain sufficient information to assess the adequacy of the ASB income thresholds and benefit amounts.

Department has not made adjustments based on seniors' needs

The Department has periodically adjusted the ASB income thresholds and cash benefits based on changes to federal programs and changes to other provincial programs, not on an assessment of seniors' needs. For example, the following adjustments made by the Department to the ASB were based mainly on availability of funding or changes to other programs:

- The July 2003 increase in income thresholds and cash benefits was driven by an expected increase in the provincial funding available for the program. Department staff prepared profiles of different dollar increases to the various thresholds and cash benefits showing the total program cost of the increases and their impact.

- A supplementary accommodation benefit of $4,455 per year was established in July 2003 for residents of long-term care facilities. This benefit was designed to offset the impact of the government's decision to charge seniors in long-term care facilities increased accommodation charges.

- The increase to the maximum cash benefit for the lodge residents' category from $1,800 to $2,820 allowed lodge owners to charge seniors higher rates. The intent of the increase was to leave seniors with $265 disposable income every month, the same residual amount they were left with before the increase in the accommodation charge.

Benefits may not be sufficient to meet needs of seniors in supportive living facilities

The Department also does not have information to determine whether the needs of seniors in various supportive living settings, such as assisted living, are being adequately met by the current benefits. During our audit, we were informed by Authorities and some individuals that the costs of some of these settings are so significant that many seniors cannot afford to live in them. In many cases, the costs of living in an assisted living setting are similar to the cost of long-term care facilities but residents in the assisted living settings do not qualify for the supplementary benefit. This is an issue because the government's objective is to shift seniors from long-term care facilities to supportive living settings. However, without adequate support, seniors may not be able to afford to live in supportive living settings.

In our opinion, the ASB threshold and benefits should be based on seniors' needs and the Department should have sufficient information to determine the needs.

Implications and risks if recommendation not implemented

Without information on the appropriateness of the ASB income threshold and benefit amounts, the Department's plan for future program funding requirements may not be adequate.

Our visits to regional health authorities

Summary of findings

We visited all nine regional health authorities (Authorities) to assess if they had appropriate systems in place to enable them to meet their responsibilities for services provided in long-term care facilities. We have used the following numbers to identify the Authorities:

Regional Health Authority	Authority #
Chinook Regional Health Authority	1
Palliser Health Region	2
Calgary Health Region	3
David Thompson Regional Health Authority	4
East Central Health	5
Capital Health	6
Aspen Regional Health Authority	7
Peace Country Health	8
Northern Lights Health Region	9

Authorities are responsible for the services provided in long-term care facilities, which include contracting for or operating long-term care facilities in their regions and monitoring the quality of health care provided in the facilities. Our significant findings are:

1. All Authorities have issued guidelines or policies and procedures of their own to either clarify or add to the *Basic Service Standards for Continuing Care Centres* issued in 1995 by the Department of Health and Wellness (the Department). These guidelines and policies and procedures differ among the Authorities. Authorities agree that the Basic Standards are outdated, but they have not recommended specific changes to the Department. However, the Department has not requested that they do so.

2. Authorities 3 and 6 conduct various reviews of facilities, and Authority 8 began conducting operational reviews at the time of our audit. However, no Authorities use an independent inspection process to determine whether facilities comply with all of the Basic Standards.

3. The methods that Authorities have established to measure whether the services provided in long-term care facilities are effective vary across the Authorities; the amount and type of financial and quality information that Authorities collect, and the extent of the analysis performed on the information, differs.

4. The accountability relationships between Authorities and facilities operating in their regions differ throughout the Province. Seven Authorities have set out clear responsibilities for contracted facilities in agreements or service expectations letters, but only Authorities 3 and 6 have set targets or benchmarks for the performance information that they require all facilities in their regions to report. No Authorities obtain annual written assurance from the contracted facility operators that they have operated in compliance with applicable sections of the Acts, Basic Standards, guidelines, and policies and procedures.

5. All Authorities projected their future needs for services provided in long-term care facilities in their Ten-Year Continuing Care Strategic Service Plans (2002–2012). Authority 2 has updated its Plan to reflect the boundary changes of April 2003, and Authorities 1 and 5 do not intend to update their Plans because their continuing care resident population was not significantly affected by the boundary change. The remaining six Authorities are in the process of updating their Plans. No Authorities have measured, evaluated, and reported on the achievement of all of the goals and strategies in the Plans.

Detailed findings

In the following table, we highlight significant findings from our visits to Authorities. We have made specific recommendations to each Authority based on our assessment of the systems in place at each.

Criteria	Comments
1. Authorities should have systems to develop and maintain current standards for services provided in long-term care facilities. Authorities should: • have standards for services provided in long-term care facilities • periodically review the standards to ensure they are current and relevant • use information gathered from monitoring compliance with standards to determine whether changes are required • consider the results of complaints, incidents and investigations when reviewing the standards • periodically obtain feedback on the standards from key stakeholders such as professional organizations and facilities • establish a process to recommend and approve changes to the standards • communicate standards to facility operators	**Results** All Authorities partly met this criterion. **Standards** All Authorities have issued guidelines or policies and procedures of their own to either clarify or add to the Basic Standards. The number and type of guidelines or policies and procedures that the Authorities have issued varies; for example, Authority 6 has issued guidelines and policies and procedures in many areas such as infection prevention and control, wound care, hygiene, diabetes management, regional disaster planning, P3 standards, post-falls assessment, and pharmacy and therapeutic. **Changes to standards** All Authorities, other than Authorities 4 and 7, have processes in place to review their internal guidelines and policies and procedures to ensure that they are current and relevant. All Authorities use information from the facilities, information on complaints and incidents, special reviews of facilities, and results of PPIC and HFRC investigations to assess whether to change guidelines and policies and procedures. In cases where Authorities determine that a Basic Standard needs clarification, they will issue a new guideline or policy and procedure. For example, all Authorities have established their own guidelines or policies and procedures to update the Department's Basic Standard for nursing and personal care of residents because the Basic Standard of 1.9 paid hours per resident day was not adequate to meet the increasing care needs in their facilities. During our review of long-term care facilities in the Province, and during our discussions with the Authorities, we received numerous comments from facility operators and Authority personnel that many of the Basic Standards were outdated, unreasonable, or unclear. However, we did not see evidence that Authorities had recommended specific changes to the Department. **Communicating standards** All Authorities have processes to communicate new Basic Standards, guidelines, policies and procedures to facilities. Five Authorities (3, 4, 7, 8, 9) are still in the process of reviewing all of the policies and procedures manuals of the former Authorities, selecting the most relevant, and integrating them for consistency across their regions. Therefore, some of the

Criteria	Comments
	facilities in these regions were still using the policies and procedures manual of the Authority that they belonged to before the boundary changes effective April 2003.
2. Authorities should have systems to ensure compliance with standards for services provided in long-term care facilities. Authorities should: • have systems to ensure that services provided in facilities comply with standards set by the Department and processes to rectify non-compliance • have a process to promptly assess and investigate complaints about services provided in long-term care facilities • promptly investigate reportable incidents in facilities • inspect facilities for compliance with standards • provide information to the Department on complaints and reportable incidents • take corrective action to rectify instances of non-compliance identified during investigations of complaints, reportable incidents, and facility inspections • monitor trends in the number and nature of complaints and incidents	**Results** Three Authorities (3, 6, 8) partly met and the remaining Authorities did not meet this criterion. **Compliance with standards** All Authorities have set out the expectation for facilities (both their owned and contracted facilities) to comply with the established Basic Standards, guidelines, policies and procedures. **Complaints and incidents** All Authorities have systems in place to promptly assess and investigate the complaints and incidents reported by the facilities, as well as the complaints that the Authorities receive directly. Authorities differ in the amount of information they require to be reported to them on complaints and incidents. Authorities 1, 4, 5, 7, and 9 receive information on the number and nature of complaints and incidents from owned facilities and critical incidents from contracted facilities; Authorities 3 and 6 require only critical incidents to be reported to them. Authorities 7 and 9 have not defined a critical incident, even though Authority 7 requires critical incidents to be reported. Authority 8 requires both owned and contracted facilities to report the number and nature of incidents, as well as critical incidents. Authority 2 requires owned facilities to report the number and nature of complaints and incidents, and contracted facilities to report the number and nature of complaints, but does not require contracted facilities to report any incidents. All Authorities have systems in place to monitor trends in the number and nature of complaints and incidents that are reported to them. Because there is no formal directive from the Department of Health and Wellness on communicating complaints and reportable incidents, Authorities report complaints and incidents to the Department at their discretion. All Authorities have systems in place to rectify instances of non-compliance if they are brought to their attention. Authorities appropriately investigate complaints and reportable incidents, take action on results of investigations of the Health Facilities Review Committee and Protection for Persons in Care, and ensure that response letters are sent to these organizations.

Criteria	Comments
	Facility inspections and corrective action Authorities 3 and 6 conduct various reviews of facilities, such as quality reviews, pharmacy reviews, critical incident reviews, morbidity and mortality reviews, chart reviews, public health inspections, or environmental health inspections. Authority 8 began conducting operational reviews at the time of our audit, which will examine whether the Basic Standards are being met. Representatives from all other Authorities make informal visits to the facilities and may conduct reviews if there is a critical incident. However, no Authorities have systems in place to monitor or inspect whether facilities comply with all Basic Standards in effect using an independent inspection process. As reported in Appendix B, we visited 25 facilities in all nine regions of the Province: 13 contracted and 12 owned by Authorities. The purpose of our review was to determine whether the facilities complied with the Basic Standards. We found that services provided in long-term care facilities do not consistently comply with the Basic Standards. Authorities and facility operators or managers explained to us that some Basic Standards were not met because the Basic Standards are outdated, unreasonable, or unclear. However, we found numerous examples of facilities not meeting the Basic Standards, which could result in reduced levels of care and increased risk to residents. Our findings in Appendix B suggest that, even though Authorities visit facilities regularly and some conduct reviews of the facilities, long-term care facilities in the Province are not operating consistently in compliance with the Basic Standards.
3. Authorities should have systems to periodically measure, evaluate and report on the effectiveness of services provided in long-term care facilities. Authorities should: • define the purpose and objectives of services provided in long-term care facilities • establish methods to measure whether the objectives are being met	**Results** All Authorities partly met this criterion. **Objectives and measures** All of the Authorities have defined the purpose and objectives of the services provided in long-term care facilities in their Ten-Year Continuing Care Strategic Service Plans (2002–2012). The methods that Authorities have established to measure whether the objectives are being met vary across the Authorities; the amount and type of financial and quality information, and the extent of the analysis performed on the information differs significantly. All Authorities collect both financial and quality of care information from the facilities in

Criteria	Comments
• have information systems to obtain reliable cost and results information promptly • analyze performance information and use it to recommend changes to the services provided in long-term care facilities • report performance information to their respective Minister	their regions, but the amount and type of information varies by Authority and in the case of Authority 1, it varies depending on whether the facilities are owned or contracted. Authorities 3, 4, and 6 require all of their facilities to report on a comprehensive set of performance indicators such as resident falls, chronic wounds, tuberculosis screening rates, influenza immunization rates, drug requests, PPIC investigations, HFRC recommendations, outbreak occurrence, accreditation status, and occupancy rates. These Authorities use service expectations letters to communicate these requirements. In addition to collecting some of the information noted above for all of their facilities, Authority 1 has implemented the Minimum Data Set (MDS) for its owned facilities and uses quality indicators to evaluate the facilities' performance. Twenty-four quality indicators are derived from the MDS assessments; they are designed to examine quality of life and health measures for clients. The quality indicators involve accidents, behavioural and emotional patterns, clinical management, cognitive patterns, elimination and incontinence, infection control, nutrition and feeding, physical functioning, psychotropic drug use, quality of life, and skin care. The remaining five Authorities require either a few performance indicators to be reported to them or have some performance indicators voluntarily reported to them. **Obtaining and analyzing information** Authorities told us that they use the financial and quality of care information that they collect to determine whether the services provided in long-term care facilities are effective. However, we saw little evidence that Authorities analyze financial information in relation to the quality of care information they receive from long-term care facilities. We saw little evidence that Authorities set benchmarks for financial and quality of care indicators to use as a basis for comparison between other facilities in the region, among other Authorities, or other jurisdictions. Once all Authorities implement the MDS system, it will give them the data to effectively compare cost and quality both within and among Authorities, and to analyze cost effectiveness. **Funding** All Authorities fund their contracted long-term care facilities

Criteria	Comments
	based on the original Department of Health and Wellness Long-Term Care Funding Model, which is based on number of beds, number of residents (assuming a 99% occupancy rate), and the Three-Year Average Case Mix Index (CMI). There are detailed formulas to calculate direct care nursing funding, therapeutic services funding, and support services funding. Each Authority has customized the Model. Facility funding levels differ among the Authorities; funding varies by up to $10,000 per year per bed. While we expected some differences in funding levels between the regions due to things like differing resident functional care needs, staff mixes, funded rates per hour for nursing time, and number of funded paid hours per resident day, we were unable to obtain information to explain the large range in funding. Also, since information about the quality of services achieved by each region was not available, we could not assess if the Authorities that spend more achieve better results than the Authorities that spend less. **Reporting** All Authorities share financial information with their Board of Directors and some Authorities share quality of care information. No Authorities specifically report to the Department of Health and Wellness on the effectiveness of long-term care facilities because the Department has not asked them to. Occasionally, the Department may request certain information, and Authorities will provide it.
4. Authorities should establish a system to ensure that legislated responsibilities for services in long-term care facilities are fulfilled. Authorities should: • be aware of their responsibilities for services in long-term care facilities as outlined in the relevant acts and regulations • have an accountability framework in place with the Department that sets out responsibilities, performance expectations and the requirement to report on	**Results** All Authorities partly met this criterion. **Responsibilities** All Authorities have systems in place to ensure that they remain aware of their responsibilities for services in long-term care facilities as outlined in the various acts, regulations and directives. All Authorities have systems in place to ensure that all facilities in their regions are aware of new or amended legislation. **Accountability framework with the Department** In November 2004, the Department provided guidance to Authorities on preparing accountability documents, including the factors and measures that Authorities should include in their Three-Year Health Plans, including a number of factors and measures on continuing care.

Criteria	Comments
results achieved • have signed agreements with the contracted facility operators that set out responsibilities, performance expectations and the requirement to report on results • have systems to monitor and report on compliance to the Department	The Department requires Authorities to prepare and submit Three-Year Health Plans and Annual Business Plans that include performance expectations, and an Annual Report to report on results achieved. We did not review all of the 2005–2008 Three-Year Health Plans or Annual Business Plans because they were not complete at the time of our review; however, of the three that we did review (Authorities 1, 6, and 7), we found that Authorities 1 and 6 had not incorporated all of the key factors as required by the Department in their Plans. Because the fiscal year is still in process, the Plans have not been reported on; therefore, we are unable to report whether the Authorities reported on results in accordance with the Department's requirements. All Authorities told us that they were planning to obtain the necessary data to report on all of the measures required by the Department in their March 31, 2005 annual reports. **Agreements with facilities** All Authorities have systems in place to communicate responsibilities to their owned facilities by meeting with the facility managers, and by setting out the responsibilities in Authorities' policies and procedures manuals. Seven Authorities have set out clear responsibilities for contracted facilities through either the agreements in place with the facility operators or service expectations letters. However, one agreement in place between a facility operator and Authority 4 that we selected for review does not set out clear responsibilities, and the agreement between Authority 8 and its contracted facility operator does not set out clear responsibilities, and has expired. The agreements between Authorities and facility operators vary significantly across the Province. Some include only the responsibility to provide nursing home care in accordance with the acts, laws, and regulations in effect; others include a more comprehensive list of facility operators' responsibilities such as personnel, medical staff, participation in the Authorities' assessment and placement process, accountability to the Authorities, deficiencies and deficits, books and records, information and reports, resident records, capital renewal and maintenance, equipment maintenance, liabilities, care of residents, and compliance with standards, acts, and regulations. Authorities told us that they were planning to collaborate to draft standardized agreements to use throughout the Province.

Criteria	Comments
	The processes that Authorities use for setting out performance expectations and the requirement to report on results achieved vary significantly across the Authorities. Authorities 1, 3, 4, and 6 set out the information that they require from the facilities using service expectations letters or a quality improvement framework, but Authority 1 only does this for its owned facilities. Authorities 1, 3, and 6 set targets or benchmarks for the performance indicators and require facilities to report back on the results achieved if the targets are not met, but Authority 1 only does this for its owned facilities. Authorities 2 and 4 have plans in place to implement similar processes. Authorities 5, 7, 8, and 9 have not set performance expectations or targets, or the requirement to report on results achieved against the targets. **Monitoring and reporting on compliance with legislation** All Authorities receive some information from the facilities that helps them identify potential areas where facilities may not be in compliance with legislation. Authorities analyze the information reported to them and will investigate if there are any instances of non-compliance. This information helps Authorities determine whether a facility does not comply with legislation, but may not identify all areas of non-compliance. No Authorities obtain annual written assurance from the contracted facility operators that they have operated in compliance with legislation. Authorities do not report compliance with legislation to the Department because they have not been asked to do so.
5. Authorities should have systems to determine and strategies to meet future needs for services in long-term care facilities. Authorities should: • obtain information on projected future needs for services provided in long-term care facilities • have plans that describe how the needs will be met • measure, evaluate and report on the achievement of results	**Results** All Authorities partly met this criterion. **Information on future needs** All Authorities projected their future needs, and highlighted strategies to meet those needs in their Ten-Year Continuing Care Strategic Service Plans (2002–2012). Effective April 1, 2003, boundaries of Authorities were re-aligned to reduce the number of Authorities to nine to improve efficiency and provide more effective service delivery. The effect of the boundary re-alignment differed among the Authorities; some merged with as many as three other Authorities and others were not affected at all. Of the eight Authorities (2, 3, 4, 5, 6, 7, 8, and 9) affected by the boundary change, Authority 2 has already updated its Plan,

Criteria	Comments
	Authority 5 does not intend to update its Plan because the strategies in its existing Plan are still relevant, and the other six are updating their Plans. These six Authorities are in varying stages of completion; they plan to release their Plans between 2005 and 2007. To assist Authorities in preparing the Plans, the Department developed a Regional Continuing Care Model (RCCM), a projection and planning tool that uses a scenario approach and allows Authorities to analyze the effects of a wide range of assumptions on their continuing care services. The scenarios differ in the level of decline in facility-based use rates for those individuals with light to moderate care needs. Authorities have information on the demographics of their regions from RCCM, and can choose a scenario for delivering care. They determine what the bed needs will be in their region in different streams of care based on this information. From the bed needs, Authorities determine capital and cost requirements. Authority 2 and the other six Authorities that are updating their Plans are using RCCM as a basis for comparison to their own data projections, but Authorities 7 and 8 have noted concerns with the data in the model because they have found differences between their rural population projections and those in RCCM. **Developing plans to meet future needs** The Ten-Year Continuing Care Strategic Service Plans (2002–2012) outline how the Authorities plan to meet their continuing care needs in long-term care facilities, as well as in the home living and supportive living streams. Although the Plans differ in detail and format, they all outline goals and strategies that align with the Department's nine strategic directions in "Strategic Directions and Future Actions: Healthy Aging and Continued Care in Alberta". In cases where the Plans have been updated for the boundary change, or where the Plans did not need to be updated because the boundary change did not significantly affect them, all the structural needs identified in the Plans were included in the Authorities' Long-Term Capital Plans. **Measuring, evaluating, and reporting results** In their reporting to the Board of Directors and to the Department, all Authorities report on certain elements of their Ten-Year Continuing Care Strategic Service Plans. However, no Authorities measure, evaluate and report on the achievement of all the goals and strategies in the Plans.

Our visits to long-term care facilities

Summary of findings

We visited a sample of 25 facilities across Alberta and assessed each facility's operations against the following 23 criteria:

- 11 Basic Standards—care
- 7 Basic Standards—housing
- 3 Basic Standards—administration
- 2 Contractual requirements

No facilities in our sample met all 23 criteria, and only 3 criteria were fully met by all facilities. Accordingly, we conclude that there is a strong likelihood of non-compliance against many Basic Standards in facilities across Alberta, with a resulting risk of diminished quality of care. Further, we conclude that Department and Authority systems at the program delivery level relative to the Basic Standards are not effective.

The following table shows the success of facilities in meeting the criteria:

Table 9 – Facility average success rate of meeting criteria

Criteria	Met	Partly / Not Met
Basic Standards – care	68.7%	31.3%
Basic Standards – housing	88.6%	11.4%
Basic Standards – administration	49.3%	50.7%
Contractual requirements	72.0%	28.0%

Overall, we are most concerned about facilities failing to meet criteria for:

- providing medication to residents,
- maintaining medical records, particularly the application and recording of physical and chemical restraints, and
- developing, implementing and monitoring resident care plans.

There was no significant correlation between responsible Authority, location, size, ownership, or level of resident needs to a facility's success in meeting a criterion. We identified, in a separate report to each Authority, all results from facility visits for the applicable Authority and have left the resolution and follow-up of any issues to the Authorities and the facilities involved.

Following are highlights of our findings:

1. Most facilities maintained staff levels in accordance with the Basic Standards. However, we saw instances where the number of RNs employed or present at a facility failed to meet the required Basic Standard, or where LPNs were inappropriately substituted for RNs. We saw one case where administrative, payroll or housekeeping duties were reported to Authorities as nursing hours; in another facility personal care attendants were heavily tasked with housekeeping duties. Some rural facilities had challenges in recruiting qualified nurses, and many RNs are required to carry out administrative duties, which affects their available time to provide direct nursing care.

2. Although we saw ample evidence of frequent and regular physician contact with residents, approximately half of the facilities we visited did not ensure that residents received complete annual medical assessments from physicians. We understand that the validity of this Basic Standard is the subject of some debate in the medical community, as some physicians question the benefit of yearly physical assessments if there are frequent and regular visits.

3. In over half of the facilities, we saw inconsistencies in decision making, evaluation of outcomes, policy, procedure, practice and charting methodology in the use of chemical and physical restraints. Some facilities use a "no restraint" policy, while others use chemical or physical restraints, often without adequate documentation, and in a few isolated cases, without apparent medical authorization required by the Basic Standards.

4. Only 7 of 25 facilities fully met Basic Standards relative to the provision, administration and management of medication to residents. We witnessed unlocked and unattended medication carts, inconsistent recording of medication outcomes, frequent inadequate reporting and follow-up of medication errors, and staff completing medication administration procedures that did not comply with professional practice standards.

5. All facilities had individualized resident care plans in one form or another, but many did not update or monitor achievement of measurable time-lined outcomes. Care plans are critical as they provide an interdisciplinary assessment of a resident's changing functional and medical needs, provide staff with tools to measure progress against outcome measures within agreed upon timelines, and allow changes to be quickly identified.

6. Two facilities appeared to schedule resident care for the convenience of their staff, not necessarily following the care plans or the residents' needs or wishes. In one case, staff were instructed by facility management to wash and dress residents who were awake as early as 3:00 AM even though breakfast was not served until 8:00 AM. In another facility, 75% of the residents were in bed by 7:00 PM.

7. Most facilities met the Basic Standard in assessing user fees. However, we saw considerable variations in practice between facilities in interpreting the Basic Standard and assessing fees to residents for things such as transportation to medically necessary appointments, bed alarms, restraint systems, relocation between rooms in a facility and use of "hip-saver" pads to cushion residents in case of falls. In one case, a facility charged residents between $5 and $10 to transport medical specimens to a laboratory for physician ordered analysis. The variations in practice suggest that either the Basic Standard is out of date or not sufficiently clear to provide consistent direction.

8. Most facilities collected quality and performance indicator data, such as the frequency of falls, incidence of skin breakdowns, infections, unusual incidents and complaints. However, few facilities consistently analyzed this data to understand trends or patterns which may arise. Therefore, root cause analysis was not always done.

9. Most facilities did not maintain records of resident personal effects. They advised us that they take the view that the Basic Standard was outdated and resident property was not their responsibility.

10. Some facilities and Authorities did not handle contractual matters promptly. There were numerous instances of contracts lapsing before renewal, and one case where a contract with a facility expired in 1997 and had not been renewed as at December 2004.

Detailed findings

Following are the combined results of our 25 facility visits. Under the Criteria column are the Basic Standards or requirements that we used to measure the facility's performance. We grouped the criteria as follows:

- **Basic Standards—care 1 to 11**—the facility should have systems to ensure compliance with standards for personal care. Facilities should have good medical record keeping and reporting as required by legislation, policy or contractual obligation.

- **Basic Standards—housing 12 to 18**—the facility should have systems to ensure safe and adequate food and shelter.

- **Basic Standards—administration 19 to 21**—the facility operators should have systems to adequately monitor their quality of care and administer resident property.

- **Contractual requirements 22 and 23**—the facility understands and complies with contractual obligations, and has an appropriate system to document, investigate, report and take appropriate action resulting from complaints and incidents.

	Criteria (Basic Standards—care)	Results (All facilities)	Comments (All facilities)
1	**Provision of nursing and personal services** At a minimum: • 2 staff on-duty at all times, one of whom is an RN, RPN or CGN (Certified Graduate Nurse, who has completed the RN program but not fully qualified for the designation). • 1.9 paid hours average per resident day of nursing and personal care and 22% of those hours provided by nurses. • Director of Nursing hours not included in nursing time.	17–Met 4–Partly Met 4–Not Met	Most facilities met this Basic Standard, with the required portion of that care being provided by RNs. Some facilities are experiencing difficulty recruiting RNs and are attempting to meet these Basic Standards using LPNs. The Basic Standard does not define an LPN as a nurse. Although LPNs are defined as nurses in *The Health Professions Act*, the professional competencies of RNs, CGNs and RPNs are different from LPNs, thus their roles are not necessarily interchangeable. One facility was improperly recording hours for administrative, payroll and housekeeping personnel as nursing and personal care hours, in order to meet the Basic Standard. Another facility tasked nightshift personal care attendants with considerable housekeeping duties. RNs and Directors of Care face increasing administrative duties, which often impair their ability to provide nursing care hours. Some facilities used their Director of Care as an "on-call" RN when no RNs were in the facility.
2	**Life enrichment services part of basic care** • Identified staff are solely responsible for life enrichment. • Residents are encouraged to leave the facility if they are able to shop, visit or attend activities. • Religious and spiritual guidance should be available.	21–Met 4–Partly Met	Most facilities met this Basic Standard. Most residents had access to religious services. Most facilities had regular outings and many allowed for resident pets. In some cases, the size of a facility limited the amount of one-to-one recreational therapy available. Some facilities have limited recreational therapy sessions in favour of activities that may keep residents occupied, but may not necessarily provide the therapeutic benefits that the Basic Standard contemplates.

	Criteria (Basic Standards—care)	Results (All facilities)	Comments (All facilities)
3	**Provision of physician services** • Each resident is cared for by a physician, and is examined yearly • The facility has a medical director.	12–Met 12–Partly Met 1–Not Met	Yearly physical examinations were not conducted consistently across our sample facilities. We were told by several facilities that many physicians think that yearly physical examinations were not required because regular resident visits replace the yearly examinations.
4	**Access to diagnostic services** • Diagnostic services are available and properly recorded on health records.	25–Met	All facilities met the Basic Standard for resident access to diagnostic services, and the results of those services were managed and documented in accordance with the Basic Standards.
5	**Maintenance of health records** • Adequate and complete records are kept for each resident • Restraints are used in accordance with facility policy and standards. • The circumstances of ordering, type, period of use, and frequency of observation are documented on the resident health record.	9–Met 16–Partly Met	Many facilities did not meet this Basic Standard, largely as a result of their use of chemical and physical restraints. We saw inconsistencies in policies, procedures, practice, decision making, evaluation of outcomes, charting methodology and involvement of family members. Some facilities utilize a "no restraint" policy, whereas others utilize chemical or physical restraints, often without adequate documentation and in a few isolated cases, without apparent authorization.
6	**Therapeutic and special diets as part of basic care** • Therapeutic diets are ordered by a physician • Appropriate feeding techniques are used for those residents who have swallowing difficulties.	21–Met 3–Partly Met 1–Not Met	Most facilities met this Basic Standard. Some facilities had problems meeting the required consistency of some diets, and physician orders for special diets were not sufficiently documented in a small number of cases.

	Criteria (Basic Standards—care)	Results (All facilities)	Comments (All facilities)
7	**Medication to residents** • Medication is ordered, received, stored, secured, distributed, recorded on resident charts and if necessary disposed of in accordance with appropriate policies and practices. • Residents admitted with existing medication are assessed and the contents of any medication are verified.	7–Met 16–Partly Met 2–Not Met	Most facilities did not fully meet the Basic Standard relative to medication administration to residents. We identified the following practices that pose significant safety risks: • inconsistent documentation of the effectiveness and adverse affects of medication therapies, particularly relative to pain control and chemical restraint • inadequate security and storage • pre-pouring of medications • inconsistent control over phone orders signed off by physicians • insufficient or untimely notification of physicians or pharmacists following medication errors. Some facilities that were blended with acute care services experienced staff being interrupted by emergencies and failing to complete resident dosage administration. Most facilities did thorough and frequent interdisciplinary (e.g. physician, pharmacist and nurse) reviews of resident medication requirements.
8	**New admission processes** • Residents are admitted according to established waitlist criteria and approved assessment process. • Applicants are subject of a complete medical exam prior to admission including Tuberculosis (TB) screening and assessment.	18–Met 7–Partly Met	Most facilities met the Basic Standard relative to new admissions. In a number of cases, documents evidencing a physical examination and Tuberculosis (TB) test were not on resident files. Some facilities viewed TB screening to be a responsibility of the Authority, but evidence of completed screening was not retained on facility records.

	Criteria (Basic Standards—care)	Results (All facilities)	Comments (All facilities)
9	**Developing, implementing and monitoring resident care plans** • Resident schedules are based on resident needs and not staff or facility convenience. • A multidisciplinary care plan is developed after admission, and is implemented, monitored and revised to achieve intended outcomes, which are documented. • Current status of a resident is documented at least monthly, and unusual incidents affecting the resident are documented and considered in the care plan.	10–Met 13–Partly Met 2–Not Met	Care plans often did not include goals, time frames or outcomes. Some facilities had few or no interdisciplinary team (physician, nurse, dietician, pharmacist, rehabilitation therapist, care attendant) conferences and little or no updating on resident care plans. Some examples of resident scheduling problems in three separate facilities were: • One facility with a policy to dress awake residents starting at 3:00 AM for 8:00 AM breakfast. We confirmed with facility management that this policy was current and followed regularly. • One facility having the majority of residents in bed by 7:00 PM. • One facility sedating restless residents between midnight and 2:00 AM and placing them in a wheelchair by the nurses' station until they were asleep.
10	**Coordination of temporary resident absences** Residents can enjoy unlimited social and overnight leave limited only by resident discretion and ability.	25–Met	In all cases, facilities encouraged residents to visit outside the facilities, and handled their absences in a manner that met the Basic Standard.
11	**Handling of resident deaths** • Resident deaths are handled in accordance with appropriate policies and procedures. • Death certificates are administered in accordance with legislation.	24–Met 1–Partly Met	Deaths of residents were consistently handled in accordance with the Basic Standard. However, one facility's policy stipulated issue of a death certificate within 48 hours of death, which does not meet the Basic Standard of 24 hours.

	Criteria (Basic Standards—housing)	Results (All facilities)	Comments (All facilities)
12	**Meals** • Resident food intake is monitored and served quickly at an appropriate temperature. • Three meals daily plus snacks are available. • Menus frequently change, are prepared and approved by a dietician, and meet the Canada Food Guide. Menus are posted, retained and available for inspection. • Special needs are accommodated.	22–Met 3–Partly Met	Most facilities provided meals to their residents that met the Basic Standard. One facility that recently opened did not have a fully developed snack program, and two facilities had considerable problems maintaining appropriate food temperatures.
13	**Laundry** • Adequate linen / towels, and laundry services are provided	25–Met	All facilities met the Basic Standard for laundry services. There were adequate supplies of linen and towels. Charges for personal laundry varied among facilities but fees were typically between $25 and $40 per month.
14	**Maintenance of buildings, equipment and grounds** • Operating certificates are current and there is a current and reasonable preventive maintenance program. • Electrical equipment is inspected and fire exits are clear and accessible.	21–Met 4–Partly Met	Most facilities had a preventative maintenance program in place to ensure a safe environment. In some cases, residents were allowed to use electrical devices without an examination by facility staff to ensure safety, and one facility focused on reacting to problems rather than initiating an active preventative maintenance program. A number of facilities have gone to considerable lengths to create pleasant garden-like outdoor living spaces for their residents.

	Criteria (Basic Standards—housing)	Results (All facilities)	Comments (All facilities)
15	**Programs relative to safety and security** • There is a health program for staff (e.g. flu shots encouraged). • There are waste management, fire prevention and disaster recovery programs, complete with training. • The facility is maintained in a safe and hygienic condition, with an infection control committee and adequate processes and programs to control infectious outbreaks.	21–Met 4–Partly Met	Most facilities had outbreak and infection management control processes and procedures that met the Basic Standard. Some facilities had inadequate or outdated disaster plans and in some cases potentially dangerous cleaning chemicals were not safely stored.
16	**Collection of user fees** • Appropriate notification is provided to residents and families about user fees. • The facility does not charge residents for supplies or services that are included in directives as being available at public expense.	21–Met 4–Partly Met	In most cases, user fees were collected from residents in accordance with the Basic Standard, after proper notification. However, because standards are not clear some residents were charged for: • restraint systems, including repairs • hip-savers • bed alarms • rental for geri-chairs In one facility, residents were charged between $5 and $10 to deliver physician ordered specimens to the laboratory for testing. In another facility, a resident was assessed $200 when he/she requested an internal room change. We also saw evidence of families purchasing equipment for use by a resident, at the request or suggestion of the facility, and then donating the equipment to the facility upon the resident's passing, thus passing the financial burden for equipment to the family members.

	Criteria (Basic Standards—housing)	Results (All facilities)	Comments (All facilities)
17	**Staff in-service education** • There is a full time staff education coordinator for facilities larger than 100 beds. • Mandatory professional training is facilitated, as well as education in programs such as gerontology, fire prevention, disasters, infection control and dementia. • Participation is tracked by the facility and reported annually.	22–Met 2–Partly Met 1–Not Met	Most facilities had training opportunities provided for staff that met the Basic Standard. Some privately owned facilities did not compensate staff to attend non-mandatory training, which negatively affect attendance levels and therefore staff knowledge. In some facilities, staff shortages required educators to backfill vacant shifts, further affecting education opportunities for staff and also the facility's ability to release key staff from care duties for education.
18	**Provision of ambulance and transportation services** • The facility has a policy on transportation of residents to medical appointments and diagnostic treatments. • Transportation is provided at no expense to the resident if treatment is medically necessary.	23–Met 2–Not Met	Most facilities met the Basic Standard of providing ambulance service and transportation for medically necessary procedures to their residents. In two facilities, residents paid for all their transportation from the facility, regardless of medical necessity, and in one case residents were charged for staff time to arrange transportation for them.

	Criteria (Basic Standards—administration)	Results (All facilities)	Comments (All facilities)
19	**Administration services** • Facilities participate in organization wide quality monitoring and are striving to meet the standards for accreditation established by the Canadian Council on Health Services Accreditation (CCHSA)	17–Met 7–Partly Met 1–Not Met	Those facilities not fully meeting this Basic Standard: • did not have a formal quality assurance program, or • were inconsistent in the reporting of performance and quality indicators such as falls, wounds, incidents and complaints, or • were not striving to meet the requirements of accreditation by the CCHSA. In some cases, performance indicators were being recorded and reported, but facilities and authorities did not consistently analyze or trend the data.
20	**Trust accounts for residents** • Resident funds are maintained in a trust account and are available to the resident or representative upon written request. Any interest earned accrues to the benefit of residents. • Resident funds in trust accounts should not exceed $500 in any 30 day period.	16–Met 7–Partly Met 2–Not Met	Most facilities provided services to residents to provide cash for small personal purchases. In most cases, a bank account was held and cash was administered through a petty-cash chit system. In some cases, facilities held only cash, or administered balances in excess of limits. In one case, the facility did not meet the Basic Standard but provided good service with a minimum of administration by providing small amounts of cash to residents on request and invoicing the residents with their monthly rent. We found incomplete documentation in two other facilities, and one instance where the facility held over $4,000 for a resident, and was not tracking the amount or frequency of considerable cash withdrawals of several hundred dollars that had occurred in a short time.

	Criteria (Basic Standards—administration)	Results (All facilities)	Comments (All facilities)
21	**Inventory of resident personal property** • Residents are permitted to provide and maintain personal furnishings. • An inventory record of resident property is taken on admission. • Records of subsequent transactions are maintained by the facility and signed by the resident. • Safekeeping of valuables is available.	4–Met 4–Partly Met 17–Not Met	Although all facilities permitted residents to provide and maintain personal furnishings, most facilities did not meet this Basic Standard by not taking or maintaining inventories of resident property. Most facilities took the view that resident property was not their responsibility. Several facilities advised residents and families to maintain adequate insurance and minimize valuable items on site.
	Criteria (Contractual Requirements)	Results (All facilities)	Comments (All facilities)
22	**Compliance with contractual obligations** • The facility should understand its contractual obligations and have processes in place to ensure it follows them. • Facility records should demonstrate compliance with contractual obligations, including reporting on performance issues to the authority.	15–Met 8–Partly Met 2–Not Met	Most facilities not fully meeting this Basic Standard did not have current contracts or service expectation agreements in place with their respective Authorities. In some cases, facilities that were recently re-aligned into new Authorities had been operating without contracts or service expectation letters for considerable time. Some facilities did not meet this criterion due to inconsistent reporting of financial and performance data to their Authorities.

	Criteria (Contractual Requirements)	Results (All facilities)	Comments (All facilities)
23	**Documenting, investigating and reporting complaints and incidents** • The facility's policy for documenting, investigating and reporting complaints and incidents should meet contractual requirements, and be communicated by the facility to residents, families and staff. • Complaints and incidents should be assessed, investigated and reported by facilities as required by contract or authority policy. • Appropriate action should be taken by facilities on recommendations arising from investigations.	21–Met 3–Partly Met 1–Not Met	Most facilities process complaints and incidents consistent with the Basic Standard, and our visits did not reveal any incidences of particularly unusual or excessive incidents or complaints. However, there was no consistent definition of a reportable incident. In some cases: • incidents were not reported by facilities concisely to the Authority. • reporting policies and procedures at facilities were not clear. • emphasis at one facility was on not involving parties outside the facility in a dispute or incident. • incident data was not consistently analyzed or trended at the facility or Authority levels.

Our review of management bodies (lodge operators)

Summary of findings

Management bodies are responsible for operating lodges in accordance with the legislation and policy directives of the Department of Seniors and Community Supports.

We examined the systems of 20 of the 64 management bodies that operate lodges throughout the province to determine whether they have appropriate systems in place to enable them to meet their responsibilities for services provided in lodges. The significant findings arising from our examination of the management bodies are:

1. Most management bodies follow the Seniors Lodge Standards. Sixteen management bodies had their own standards in addition to the Seniors Lodge Standards. The standards set by the management bodies do not contravene the Department's standards or any legislation, but simply augment legislation and the Department's Seniors Lodge Standards.

2. Management bodies rely on lodge reviews to assess compliance with Seniors Lodge Standards but they have not occurred since 2002. Six management bodies have their own internal review process to monitor their compliance with legislation and policies. However, while these management bodies perform additional internal inspections, these inspections do not cover all lodge standards. Management bodies do not report the findings from these internal processes to the Department of Seniors and Community Supports.

3. Eighteen of the 20 management bodies performed cost analysis and used the information to prepare business plans and set user charges; two management bodies did not perform any cost analysis.

4. Nine of the 20 management bodies we examined conduct their own forecasting of future needs and incorporate it into their business plans. Seven performed limited planning, related primarily to short-term capital and maintenance needs. Four did not prepare a business plan at all.

Detailed findings

In the following table, we highlight our findings from our review of the systems of each management body that we examined.

Criteria	Results	Comments
Management bodies should have systems to ensure that responsibilities for the Seniors Lodge Program are fulfilled.		
Management bodies should be aware of their responsibilities for the Seniors Lodge Program as outlined in the relevant acts and regulations.	20–Met	All management bodies indicated they understood their responsibilities under the relevant legislation and regulations. However, a few noted that they are unclear as to the level of care they should be providing given the increased service needs of seniors residing in the lodges and the services covered by the standard accommodation charge.
Management Bodies should have standards for the Seniors Lodge Program.	Met–19 Partly met–1	Most of the management bodies met this criterion because they use the lodge standards. 16 of the 20 management bodies examined also supplemented the lodge standards with their own additional standards or guidelines.
Management Bodies should have systems to monitor and report on compliance to the Department.	1–Partly met 19–Not met	For monitoring compliance with legislation and lodge standards, most management bodies rely on lodge reviews. These have not occurred since 2002 and management bodies have not performed sufficient replacement procedures that cover all the standards or legislation, or reported results to the Department. The management body that partially met the criteria had a member of the board, the CAO and the lodge operator conduct a review of compliance with standards based on the lodge review template.

Criteria	Results	Comments
Management Bodies should have systems to ensure that services provided in facilities comply with the standards set by the Departments and that there are processes to rectify non-compliance.	Met–1 Partly met–5 Not met–14	Most management bodies are still relying on the lodge reviews that have not occurred since 2002. Although some management bodies performed informal internal reviews and obtained health and safety inspections, these processes did not cover all standards and related legislation. The management body that did meet the criteria performed a review of compliance with standards with a member of the Board, the CAO and the lodge operator and used the lodge review template.
Management bodies should have a process to assess and investigate complaints about the Seniors Lodge Program.	Met–8 Partly met–10 Not met–2	Management bodies who met the criteria had a formal complaint system backed by management body policy that required documentation of complaints and their resolution. Residents were also well-informed of the system. Those that partly met the criteria had a system in place that lacked documentation, a policy or a mechanism to inform residents. Those that did not meet the criteria had no system with recipients handling each complaint as they saw fit.
Management bodies should promptly investigate reportable incidents in facilities.	Met–20	All management bodies use the definition of reportable incidents defined under the *Protection for Persons in Care (PPIC) Act*. With lodge staff and residents informed of the reporting process for PPIC, prompt investigation would result. In addition to reportable incidents, most lodges also maintained a log of resident well-being issues used regularly to ensure follow up occurs as necessary.
Corrective action should be taken to rectify instances of non-compliance identified during investigations of complaints, reportable incidents and facility inspections.	Partly met–20	When lodge reviews were conducted, non-compliance appeared to be rectified through appropriate actions. As well, incidents under the *PPIC Act* also have a follow-up process through the Ministry of Seniors and Community Supports. However, no management bodies had an adequate complaint process that would support all complaints being followed through to resolution.
Facilities should be inspected for compliance with standards.	Met–1 Not met–19	The lodge reviews are not currently occurring. Five management bodies performed informal internal reviews and obtained health and safety inspections, but these processes did not cover all standards and related legislation. The management body that did meet the criteria performed standard reviews with a member of the Board, the CAO and the lodge operator and used the lodge review template.

Criteria	Results	Comments
The Department should receive information from Management bodies on complaints and reportable incidents.	Partly met–20	Management bodies track reportable incidents, but none had a system to summarize and report complaints or reportable incidents to the Department, as the Department does not require such information. Management bodies indicated that some issues that they wanted help resolving would be communicated to their Ministry Housing Advisor at Alberta Seniors and Community Supports, but on an ad hoc basis.
The Management Bodies should report on results achieved to the Department.	20–Partly met	All management bodies provided financial statements and most provided budgets and business plans to the Ministry as required by legislation. Management bodies are not required to give any assurance to the Department that they are complying with legislation.
Management bodies should have systems to periodically measure, evaluate and report on the effectiveness of the Seniors Lodge Program		
Methods should be established to measure whether the objectives are being met.	Met–6 Partly met–7 Not met–7	Management bodies that met the criteria established specific measures to use in evaluating whether they had met the goals and objectives in their business plans. Those that partly met the criteria did not have actual measures but had specific action plans and timelines that would facilitate performance measurement. Those that did not meet the criteria either had no plans or lacked means to measure plan progress.
Performance information should be analyzed and used in recommending changes to the Seniors Lodge Program.	Met–18 Not met–2	Management bodies performed analysis of the cost of providing services to residents and made comparisons to other lodges and budgets. The respective boards also reviewed results and used the information to prepare business plans and set user charges. Two management bodies did not perform any cost analysis.
Management bodies should measure, evaluate and report on the achievement of results.	Met–8 Partly met–4 Not met–8	Management bodies that performed little or no business planning were not able to meet these criteria. Those that did meet the criteria monitored progress of plans via board meetings or plan update reports, and specifically evaluated prior year results as part of the yearly business planning process.

Criteria	Results	Comments
Management Bodies should have systems to determine and plans to meet future needs for the Seniors Lodge Program.		
Management bodies should obtain information on projected future needs for the Seniors Lodge Program.	9–Met 7–Partly met 4–Not met	Management bodies that met the criteria met future needs through business planning and obtained future needs information from national and provincial statistics, lodge residents, the community, and other sources. Those that partly met the criteria considered limited information that was often related only to short-term future capital and maintenance needs. Those that did not meet the criteria did not prepare a business plan and therefore did not collect future needs information.
There should be plans that describe how future needs will be met.	9–Met 1–Partly met 10–Not met	Management bodies who met the criteria reflected the future needs information in business plans with goals, objectives, strategies and action plans related to a variety of future needs issues such as capital replacement and expansion, care needs of seniors, range of services and programs offered, staffing, finances, etc. Those that did not fully meet the criteria did not collect sufficient information in the first place or did not create plans that were specific enough to provide direction on how to meet the needs identified.

Audit overview

Objective and scope

Our overall audit objective was to determine whether the Departments of Health and Wellness and Seniors and Community Supports have systems in place to ensure that the Ministers' responsibilities for the following services and programs are met:

1. Continuing care and housing services in long-term care facilities
2. Seniors Lodge Program
3. Alberta Seniors Benefit Program

Approach

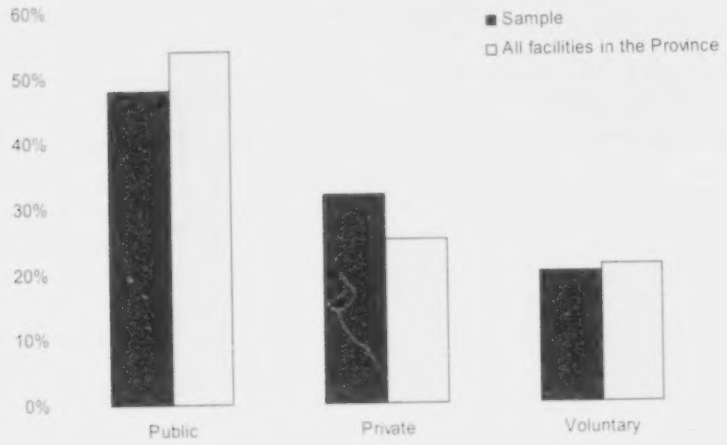
Through interviews and review of documentation, we obtained an understanding of and examined the systems at the Departments of Health and Wellness and Seniors and Community Supports. This work included an examination of the systems used by the Health Facilities Review Committee and considered the Protection for Persons in Care Office as it relates to services in long-term care facilities and seniors lodges. We also obtained and examined information and documentation from all nine Authorities on services in long-term care facilities, and from a sample of 20 of the 64 Management Bodies (lodge operators) on their systems for delivering the Seniors Lodge Program.

Long-term care facilities

We also conducted unannounced visits to 12 public, 8 private and 5 voluntary facilities located in rural and urban communities across Alberta. We visited at least one facility in each Authority. We followed a common audit plan for each visit. The facilities were located in a range of small to large communities, and varied in size from 10 to 440 beds. These visits were conducted with the cooperation of the Authorities under provisions of the *Regional Health Authorities Act* and contracts.

The following chart shows the proportions of public, private and voluntary ownership in our sample, compared to the proportions in all facilities in Alberta:

Chart 4 – Samples by ownership type [18]



Long-term care facility audit teams

We assessed the systems at each facility with a two-person audit team consisting of an auditor and a registered nurse. Each audit team had access to an advisory group consisting of a physician, a dietician, a pharmacist and an infection control specialist. The health professionals were responsible for assessing compliance with the Basic Service Standards.

We chose the health professional team members for their combination of academic qualifications and experience in the long-term care field. To maintain independence, health professionals on both the audit teams and advisory groups did not visit Authorities where they were currently or had previously been employed in a health care setting.

Long-term care facility visits

Depending on the size of the facility and the availability of information, each visit lasted between one and two days and included observation of staff to resident interaction during day, evening and night shifts. Visits consisted of reviews of documentation, interviews of health professionals and support staff, interviews of some residents and family members, observation of care practices and a review of the general environment. We compared our findings against criteria we developed from the Basic Service Standards issued by the Department of Health and Wellness. We advised facility management verbally of our findings at the end of each visit and followed up with a written report to them. Authority staff did not participate in audit procedures, but attended at the start and end of each visit to allow for an understanding of our process.

[18] Proportions of public, private and voluntary ownership in our samples compared to all facilities in the Province.

The identity of our sample long-term care facilities

The individual facilities we visited are not identified in this report and will remain confidential because:

- our audit objective was to examine the systems administered by the Departments and the Authorities that affect seniors care in Alberta.
- our sample is a representative cross-section of facilities across Alberta. Accordingly, our findings and recommendations in this report identify trends and systemic issues in all facilities, not just the sample ones.
- we reported failures to meet the Basic Service Standards to both facilities and their respective Authorities for resolution and follow-up to ensure compliance with the Basic Service Standards.

External organizations

We received submissions and other correspondence from members of the general public, professional associations, advocacy groups and industry organizations. After completing our field work, we met with delegates of the following groups and have considered their input in preparing our report.

- Alberta Association of Registered Nurses
- Alberta Gerontological Nurses Association
- Alberta Long-Term Care Association
- Alberta Medical Association
- Alberta Public Housing Administrators' Association
- Alberta Senior Citizens' Housing Association
- College of Licensed Practical Nurses of Alberta
- College of Physicians and Surgeons of Alberta
- Families Allied to Influence Responsible Elder Care
- Pharmacists Association of Alberta
- Seniors Advisory Council for Alberta

We also met with the Ombudsman for the Province of Alberta.

Criteria

We developed the following criteria to assess the adequacy of the systems that we examined at the Departments, Authorities, management bodies and long-term care facilities:

Department, Regional Health Authority, and Management Body Criteria

1. The Departments (and Authorities) should have systems to develop and maintain current standards for services and programs.

Considerations:

1.1 The Departments and Authorities should have standards for services and programs.

1.2 The Departments and Authorities should periodically review the standards to ensure they are current and relevant.

1.3 Information gathered from monitoring compliance with standards should be used to determine whether changes are required.

1.4 The results of complaints, incidents and investigations should be considered when reviewing the standards.

1.5 Feedback on the standards should be periodically obtained from key stakeholders such as professional organizations, Authorities, and Management Bodies.

1.6 There should be a process to recommend and approve changes to the standards.

1.7 Standards should be communicated to Authorities and Management Bodies.

1.8 Authorities should communicate standards to facility operators.

2. The Departments (and Authorities) should have systems to ensure compliance with standards for services and programs.

Considerations:

2.1 The Departments should have systems to monitor compliance with standards and to ensure that non-compliance is rectified.

2.2 The Authorities and Management Bodies should have systems to ensure that services provided in facilities comply with the standards set by the Departments and processes to rectify non-compliance.

2.3 There should be a process to promptly assess and investigate complaints about services and programs.

2.4 Reportable incidents in facilities should be promptly investigated.

2.5 Facilities should be inspected for compliance with standards.

2.6 The Departments should receive information from Authorities, Management Bodies and other stakeholders on complaints and reportable incidents.

2.7 Corrective action should be taken to rectify instances of non-compliance identified during investigations of complaints, reportable incidents, and facility inspections.

2.8 The Departments and Authorities should monitor trends in the number and nature of complaints and incidents.

3. The Departments (and Authorities) should have systems to periodically measure, evaluate and report on the effectiveness of services and programs.

Considerations:

3.1 The Departments and Authorities should define the purpose and objectives of the services and programs.

3.2 Methods should be established to measure whether the objectives are being met.

3.3 The Departments and Authorities should have information systems to obtain reliable cost and results information promptly.

3.4 The performance information should be analyzed and used in recommending changes to the services and programs.

3.5 The Departments (and Authorities) should report performance information to their respective Minister.

4. The Departments (and Authorities) should establish an accountability framework to ensure that responsibilities for services and programs are fulfilled.

Considerations:

4.1 The Departments, Authorities, and Management Bodies should be aware of their responsibilities for services and programs as outlined in the relevant acts and regulations.

4.2 The Departments should have issued directives and policies to the Authorities and Management Bodies to clarify roles and responsibilities.

4.3 The Departments should have signed agreements in place with Authorities and Management Bodies, that set out responsibilities, performance expectations and the requirement to report on results. The Authorities and Management Bodies should report on results achieved to the Departments.

4.4 The Authorities should have signed contracts in place with the facility operators that set out responsibilities, performance expectations and the requirement to report on results. The facility operators should report to the Authorities on results.

4.5 The Departments should have systems to monitor compliance with the applicable sections of the acts, regulations, directives, and policies.

4.6 The Authorities and Management Bodies should have systems to monitor and report on compliance to the Departments.

5. The Departments (and Authorities) should have systems to determine and strategies to meet future needs for services and programs.

Considerations:

5.1 The Departments (and Authorities) should obtain information on projected future needs for services and programs.

5.2 There should be plans that describe how the needs will be met.

5.3 The Departments (and Authorities) should measure, evaluate and report on the achievement of results.

Long-term care facility criteria

1. Facilities should have systems to ensure compliance with Basic Service Standards.

Reference in the criteria to "standards" means the document, Basic Service Standards for Continuing Care Centres, 1995 issued by Alberta Health and Wellness. This document consolidates the minimum program standards for basic services provided in long-term care facilities as defined in legislation (*Hospitals Act* and *Nursing Homes Act*), regulations, directives and other policy documents.[19]

[19] Some Directives referred to in the document became obsolete in August 2000 when Alberta Health and Wellness issued a listing of all Directives and Information Bulletins still in effect.

Considerations:
The facility should comply with standards for:
Basic Standards—care

- providing nursing and personal services.
- admitting new residents to the facility.
- developing, implementing and monitoring resident care plans.
- ongoing coordination of temporary resident absences from the facility.
- providing life enrichment services as part of basic care.
- providing medication to respite, or temporary residents.
- providing physician services.
- providing diagnostic services.
- maintaining health records.
- providing therapeutic and special diets.
- providing medication to residents.
- handling resident deaths in the facility.
- reviewing, approving and reassessing applications for admissions to the facility.

Basic Standards—housing

- collecting user fees.
- maintaining buildings, equipment and grounds to various safety codes.
- providing meals to residents.
- providing laundry services as part of basic facility services.
- providing an in-service education plan for staff.
- providing ambulance and transportation services for residents.
- developing and maintaining programs for safety and security.

Basic Standards—administration

- providing administrative services.
- providing trust account services for residents.
- maintaining an inventory of each resident's personal property.

2. Facility operators should have systems to comply with the terms of their contracts with Authorities.

Considerations:

2.1 The facility should be aware of and understand its contractual obligations.

2.2 The facility should have processes to ensure that it complies with its contractual obligations.

2.3 The facility records should document its compliance with contract requirements.

2.4 The facility should report on performance to the Authority, in the required form and timelines set out in the contract.

3. Facility operators should have systems to document, investigate, and report on incidents and complaints.

Considerations:

3.1 The facility's policy for documenting, investigating and reporting complaints and incidents should comply with contractual requirements.

3.2 The facility should communicate the policy to all residents, resident families and employees.

3.3 The facility should promptly assess all complaints and incidents and investigate them when appropriate.

3.4 The facility operator should promptly take appropriate action to implement any recommendations arising from the investigation of complaints and incidents.

3.5 The facility should report information on complaints and incidents to the Authorities and other parties as required by the contract.

In assessing whether our criteria were met, partly met or not met, we considered the following:

Criteria Met:
The entity has designed systems to meet the criteria and:

- policies are in place, current and followed
- necessary staff are knowledgeable
- management is following up, monitoring and updating systems as necessary
- audit testing found that the systems are working

Some comments on areas for improvement may be noted, but are not significant enough to warrant downgrading to Criteria Partly Met, or Criteria Not Met.

Criteria Partly Met:
A structured system is in place to meet the criteria but it:

- is not being fully followed, or
- is not monitored or updated by management, or
- does not meet all aspects of the criteria, or
- needs improvement to meet the criteria

The entity does not have a structured system in place to meet the criteria; however, management and staff have incorporated informal practices that meet some or all of the criteria.

Criteria Not Met:
The entity does not have structured or informal systems to meet criteria or a key component is missing even though other aspects of the criteria were met. Therefore, substantial or significant improvement needed.

Reporting

Departments
We shared the results of all components of our audit with both Departments. This includes the summary of the results from the Authorities (Appendix A), facilities (Appendix B), and management bodies (Appendix C).

Authorities
We reported results from the examination of the Authority's systems to each Authority. This included a summary of our findings from the facility visits we conducted in their region. We also gave Authorities a copy of the final reports for each facility in their region.

Long-Term Care Facilities
We met with each facility operator to discuss our findings at the end of each visit. Facility operators have also received a draft report on the results of our examination of their facility's systems and had an opportunity to comment on the findings. They received a final report after this feedback.

Management Bodies
All management bodies received a summary of results from the sample of management bodies that we examined.

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